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ABSTRACT

This document is the final report of the study of impact on parents of the Parent Child Centers (PCC) which are administered through Head Start, Office of Child Development (OCD). Designed for families whose incomes fall below the federally established poverty levels, the Parent-Child Center program focuses upon meeting the needs of children from the time of conception to age three, and the needs of their parents. The demonstration program explores the feasibility and outcome of having parents involved in a program with their children. This evaluative study of impact on parents centers around the program's primary objectives: to have (1) impact on parenting skills and attitudes, (2) impact on the parents' sense of self esteem and feelings of control over their environment and personal destiny, (3) impact on the parents' knowledge and use of community resources, and (4) impact on the parents' use of health facilities and on their nutrition practices. Based on the findings presented it cannot be said that the PCC program as implemented had a profound effect on the majority of parents served. However, individual parents made some gains as a result of the program. (CS)

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THE IMPACT OF THE HEAD START PARENT-CHILD CENTER PROGRAM ON PARENTS

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The PCC impact study has been conducted over a two-year period. Visits to all the Centers and participation in two national PCC conferences have made PCC an indelible part of the CCR experience. We wish to thank the staffs and parents of all the Centers for their helpfulness and hospitality. They have made the task of evaluation a great and genuine pleasure.

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EXECUTIVE SUMMARY

1.0 INTRODUCTION

This summary is of the final report of the study of impact on parents of the Parent-Child Centers (PCCs). The impact study was initiated in the fall of 1971 and has been conducted over a two year period by the Center for Community Research (CCR). Initiated in 1968, the Parent-Child Center program is administered through Head Start, Office of Child Development (OCD). There are thirty-three PCCs located in low-income neighborhoods across the United States. Each is designed to meet the needs of children from the time of conception to age three, and of their parents.

While there exists enormous variability among PCCs in terms of operations and program style and content, all must provide an educational component for children, an educational component for parents, a social services component, and a health and nutrition component. Additionally, all PCCs have on staff at least several non-professional community residents and a Policy Advisory Council, comprised of at least 50% parent-consumers.

The PCC program was not intended as a day care program in which children could be left five days a week, while the parents were otherwise engaged. Instead, the PCC program was designed as a demonstration program, which would explore the feasibility and outcome of having parents involved in a program with their children. The emphasis was to be on enhancement of parenting skills, in terms particularly of knowledge of child development, of health care, of nutrition, and of home management. Thus, in contrast to most day care programs, the PCC program was conceived as a means for strengthening parents in their parenting roles. The thrust was that of enabling and facilitating, rather than acting as a parent substitute.

The present evaluation is based on the PCC program as it exists; it therefore cannot be taken as an evaluation of the Parent Child-Center concept, per se. In practice, it has proved difficult to enlist the active and sustained participation of the majority of parents, at most of the Centers. Participation by a majority of parents in the infant and toddler programs is realized in only a minority of Centers. At most PCCs there is a small core of parents who come to all meetings and educational sessions; participation by the majority is minimal. In some communities parents are enthusiastic about involvement in the social/recreational/educational activities of the Center; however, they have rejected the idea that they should come to the PCC to play with their children. In other communities, the PCC has become a place to drop children off for a few hours a day or week, in order to obtain relief from child-rearing obligations.

Based on a representative sample of parents at a representative sample of Centers, the impact study is of a highly variable input. Some of the parents in the sample participate intensely, others only minimally. The definition of high or low involvement is relative to each Center: "high" involvement at one Center might be viewed as "low" involvement in another, in the absolute sense. Some of the parents in the sample have participated with their children, observing what staff does and trying out some of the same activities, others have used PCC primarily as a community center, and others have scarcely attended at all.

The study of impact on parents centers around four areas, defined as the programs' primary objectives by the PCC staff at the national level. The four areas are:

- Impact on parenting skills and attitudes
- Impact on the parents' sense of self-esteem and their feelings of control over their environment and personal destiny
- Impact on the parents' knowledge and use of community resources
- Impact on the parents use of health facilities and on their nutrition practices.

The study was conducted in two phases. During Phase I, data relecting program objectives and operations in every component were collected from Program Directors, staffs, and parents, during site visits made by CCR professional staff to 32 of the 33 PCCs; Alaska was not included in the study. During this phase, interviews were conducted among 327 staff and 385 parents. Using these data, the 32 projects were clustered into five groups, based on the orientation of the program on behalf of parents, and on behalf of children. Ultimately, seven PCCs were selected for impact study, after extensive discussion with the OCD Director of the PCC program and the OCD Program Coordinators. The choice of specific PCCs within a cluster was dictated by an effort to ensure as great a diversity of programs as possible, so that the entire range of programs could be represented in the sample. Additional dimensions considered in program selection included: (1) method of outreach, (2) inclusion of both urban and rural Centers, and (3) program stability during the six months preceding initiation of the evaluation. Parenthetically, the emphasis on program stability turned out to be somewhat abortive, as two of the programs moved, and two changed their entire style of program operations during the course of the evaluation. It seems that program stability prior to the inception of an evaluation does not ensure program stability following the initiation of the evaluation.

Finally, programs were excluded from consideration if they have been selected by OCD to have an Advocacy Component. By definition, these program would no longer be representative of the national PCC program, per se.

Emphasis was also placed on ensuring representation of the full range of PCC programs. Programs selected range from all-day services to children, to programs providing only two hours a week per child; from eight hours a week of mandated attendance by parents to zero hours; from home visits for all families, to home visits for none; from programs in which every component is professionally led, to programs where the entire staff is non-professional; from programs with a primary emphasis on education, to programs with a primary emphasis on social services.

Comparisons along demographic dimensions between parents at all 32 Centers, and parents at the seven Centers in which the impact study was conducted show no significant differences whatsoever. Thus, it can be said that not only the Centers included in the study are representative, but also that the parents studied are representative of those in the entire national program.

Phase II involved the study of impact on a sample of parents at the seven sample Centers. In the fall of 1972, interviews were conducted by CCR professional staff with

PS 007186

354 parents at the seven Centers. Sixty-seven of these were conducted with mothers new to the program; the remaining interviews were conducted with parents who were defined as short-term participants (6-20 months) and long-term participants (over 20 months). In addition, parents were identified by program staffs as being high or low-involved.

In order to investigate whether there was any short-term impact, all of the new parents in the program as well as a sub-sample of ongoing parents were reinterviewed after two months. No changes were evident over this short range of time.

Eight months after the initial interviewing, all parents who had been interviewed in the fall and who still remained in program (N=210; 59%) were reinterviewed. Of the 144 parents not available for reinterview, 96 had terminated their participation in the program, 23 had moved out of the catchment area, and 25 were unavailable for various reasons, e.g., illness, trips, full-time jobs, school, etc. Analyses conducted to determine whether the attenuated sample was in any way biased showed no differences in original response pattern between those who were available and those were were unavailable for final interviews.

2.0 FINDINGS

2.1 Impact on parenting knowledge and attitudes

Measurement in terms of impact on parenting skills was implemented in three different ways: (1) alternatives to everyday problem situations, (2) basic issues involved in parenting, and (3) parenting attitudes, behavior, and feelings.

2.1.1 Alternatives to everyday problems

The emphasis of this aspect of the impact study was to avoid judgments about what is "good" and "bad" parenting. It was expected that as a result of participation in program, parents would show increased awareness of the variety of options available in any situation involving children. It was hypothesized that a mother who is knowledgeable about child development would be more likely to think of a variety of reasons as to why a set of behaviors is occurring, relating this, in turn, to the developmental stage of the child and the context in which the behavior is occurring. Each parent was presented with a set of six ordinary everyday problem behaviors and asked to offer as many alternatives as she could think of for handling the child's behavior. The following is a summary of findings for each of the measures used:

- There is no evidence to support the prediction that PCC will have an impact on the number of options or alternatives available to parents in a child-centered problem situation.

- The data are supportive but not conclusive of the hypothesis that PCC has an impact on the quality of the first response made by parents in a child problem situation. PCC parents tend to be less likely to hit, deride, or isolate young children who are being bothersome, than are parents new to PCC. However, a substantial proportion of PCC parents react punitively rather than supportively or educatively, as a first option in almost any situation in which they find that a child is annoying.

- While parents are more likely to give an adaptive than a punitive response as a first alternative, changes in parents are less impressive when it comes to the full response repertoire. That is, while parents are less likely to respond punitively as a first response, following the first one or two responses there are few changes over time in terms of punitiveness. Punitive responses may be lower on the response hierarchy as a result of PCC, but they are not extinguished.

- PCC is not effective in helping a majority of parents take into account the age or the needs of the child in thinking through what should be done in a given situation. No more than 10% of parents show such awareness and sensitivity to the nuances underlying children's behavior.

2.1.2 Basic issues and feelings involved in parenting

- There are no changes over time in terms of either the age at which the parents begin toilet training or the methods which they use to achieve such training.

- There are no changes over time in terms of what parents report enjoying most about their children.

2.1.3 Parenting attitudes, behavior, and feelings

- There is some evidence which suggests that PCC participation makes parents more likely to question their adequacy as parents. It appears that as parents become increasingly aware of the complexities of parenting they become more self-critical and demanding.

- No changes in the parenting behavior measured, e.g., amount of time that the child is kept in his crib, the amount of time spent talking to babies at mealtime, are evidenced over time.

- There is little evidence to suggest that PCC has an impact on parental understanding of child development or on sensitivity to individual differences in children.

2.2 Impact on parental self-concept

- There is no evidence that PCC promotes a more trusting attitude toward other people.
- There is little evidence to support the notion that PCC has an impact on the feelings of aloneness or shyness of a large proportion of participants.
- PCC does seem to have some impact on parents' feelings that they have control over their destiny and over their sense of personal helplessness.
- Involvement in community affairs tends to be low among the majority of parents. There is slight evidence to suggest that PCC may increase the level of participation in community affairs.

2.3 Knowledge and use of community resources

- There is no evidence that participation in PCC causes a substantial number of parents to become active in other community organizations or on community boards.

- There is no evidence that participation in PCC causes a substantial number of parents to enroll in education courses. Only twenty-one parents in the sample report their enrollment in courses as a result of PCC intervention or encouragement.

- PCC does play a role in helping parents to obtain food stamps, commodities, welfare, or Medicaid. Fourteen percent of those using food stamps, 25% of those using commodities, 9% of those using welfare, and 13% of those receiving Medicaid, report PCC assistance in these areas.

- Thirty percent of the parents who have used a health clinic report that they did so with PCC assistance.

- Approximately one-third of the parents who use planned parenthood services report that they were referred for this service by PCC.

- Fifty-seven percent of the families who use Head Start report that they did so as a function of a PCC-made referral or at the suggestion of PCC staff.

- Fifty-five percent (or 38 people) of parents who use a day care or child care program report doing so with PCC assistance.

- There is no evidence that PCC has any role in referrals to the state employment office.

- Ten percent (or 5 people) of parents who participated in a job training program report that they did so as an outcome of PCC assistance.

2.4 Health and nutrition

- There is no evidence that PCC has a major impact on the quality of pre-natal care.

- PCC does play a major role in the area of immunization. A large proportion of children 0-3 years receive their immunizations as a result of PCC intervention.

- There is no evidence of PCC impact on the number of well baby visits during the first year of life, but sustained medical care for 1-4 year olds is more likely to occur among ongoing than among new PCC parents.

- PCC does have an impact on the receipt of dental care among both children and parents.

- Data collected at T1 on nutrition practices of parents, in terms of the 24 hour recall, showed no differences among any sub-groups. Therefore, this measure was dropped from the interview.

3.0 CONCLUSIONS

Based on the findings presented it cannot be said that the PCC program as implemented has a profound effect on the majority of the parents served. Yet it is impossible to have taken part in conversations with a great number of mothers and to come away with the impression that PCC has had no impact. Among some parents changes are taking place, but the variety of changes is almost as great as the number of parents interviewed. Thus, a few parents become less shy, a few are more confident of their ability to cope, a few are more sensitive to the nuances of children's behavior, and a few have been referred to various resources in the community. No single PCC component or endeavor affects a majority, and so percentages in every area of achievement are small. Thus, when the entire sample is measured, differences tend to be small and not statistically signficant; however, a few individuals have gained in almost every conceivable area.

Conversations with mothers about their lives and about PCC reveal that in some instances PCC has made a genuine difference and that the program means a great deal to them. This is not the case in all programs and it may not be the case among a majority of parents, but the life stories of parents quoted in the report itself should leave no doubt that PCC has had a profound impact on the lives of some.

TABLE OF CONTENTS

PAGE

CHAPTER I - INTRODUCTION

CHAPTER II - METHOD OF PROCEDURE

1.0 The strategy underlying the evaluation design II-1
2.0 Phase I II-3
3.0 Phase II II-9
    3.1 Impact dimensions II-9
    3.2 Questionnaire construction II-13
    3.3 Sample selection II-15
    3.4 Data analysis II-22
        3.4.1 Length of membership II-22
        3.4.2 Involvement II-25
        3.4.3 Urban vs. rural II-27
        3.4.4 Sample attrition II-28

CHAPTER III - DEMOGRAPHIC AND BACKGROUND DATA

1.0 Demographic and background data III-1
    1.1 Who was interviewed III-1
    1.2 About the respondents III-2
        1.2.1 Sex III-2
        1.2.2 Age III-2
        1.2.3 Ethnicity III-4
        1.2.4 Education III-5
    1.3 Respondents' families III-6
        1.3.1 The children: total number per family III-6
        1.3.2 Intact families III-7
    1.4 Involvement in PCC III-9
        1.4.1 Respondents' involvement - time spent at PCC III-9
        1.4.2 Time spent per week on PCC activities at home III-11
        1.4.3 Policy Advisory Council membership III-13
    1.5 Employment III-15
        1.5.1 Employment status - mothers .. III-15
        1.5.2 Employment status - fathers .. III-17
        1.5.3 Changes in employment status III-19
        1.5.4 PCC's role in aiding parents' employment III-20
    1.6 Welfare III-21
2.0 Summary III-22

TABLE OF CONTENTS - (continued)

PAGE

CHAPTER IV - PARENTING

1.0 Alternative solutions to everyday problems IV-1
  - 1.1 Stimulus materials IV-2
  - 1.2 Analyses of data IV-4
  - 1.3 "Child grabs an unwanted item while mother shops" IV-6
    - 1.3.1 The number of solutions IV-9
    - 1.3.2 Types of solutions: first response IV-11
    - 1.3.3 Types of solutions: all responses IV-15
    - 1.3.4 Age and context - relevant responses: Time 2 .... IV-19
  - 1.4 Teaching danger avoidance IV-20
    - 1.4.1 The number of solutions IV-21
    - 1.4.2 Types of solutions: first response IV-23
    - 1.4.3 Types of solutions: all responses IV-27
    - 1.4.4 Age and context - relevant solutions: Time 2 .... IV-30
  - 1.5 Nuisance termination IV-31
    - 1.5.1 The number of solutions IV-33
    - 1.5.2 Types of solutions: first response IV-35
    - 1.5.3 Types of solutions: all responses IV-38
    - 1.5.4 Age and context - relevant responses - Time 2 .... IV-42
  - 1.6 Nocturnal crying IV-43
    - 1.6.1 The number of solutions IV-44
    - 1.6.2 Types of solutions: first response IV-46
    - 1.6.3 Types of solutions: all responses IV-49
    - 1.6.4 Age and context - relevant responses: Time 2 .... IV-52
  - 1.7 Sharing behavior IV-53
    - 1.7.1 The number of solutions IV-54
    - 1.7.2 Types of solutions: first response IV-56
    - 1.7.3 Types of solutions: all responses IV-59
    - 1.7.4 Age or context - relevant responses: Time 2 .... IV-63

TABLE OF CONTENTS - (continued)

PAGE

  - 1.8 Aggression toward others IV-64
    - 1.8.1 The number of solutions IV-66
    - 1.8.2 Types of solutions: first response IV-68
    - 1.8.3 Types of solutions: all responses IV-71
    - 1.8.4 Age or context - relevant responses: Time 2 .... IV-75
  - 1.9 Summary of solutions to situations ... IV-76
- 2.0 Basic issues and feelings involved in child rearing IV-79
  - 2.1 Toilet training IV-79
    - 2.1.1 Age at which toilet training is begun IV-80
    - 2.1.2 Methods of toilet training IV-83
  - 2.2 The preasures of parenthood IV-86
    - 2.2.1 Distribution of responses IV-87
  - 2.3 Change in feelings as a result of PCC IV-90
  - 2.4 Summary of basic issues and feelings . IV-95
- 3.0 Parenting attitudes, behavior and feelings ... IV-96
  - 3.1 Feelings of adequacy as a parent IV-97
    - 3.1.1 "I feel I am a good mother" ... IV-98
    - 3.1.2 "I worry about whether I'm doing right for my children".. IV-99
    - 3.1.3 "The children are just too much for me to handle" IV-99
  - 3.2 Parenting behavior IV-101
    - 3.2.1 "I hold my baby while giving him his milk" IV-102
    - 3.2.2 "I keep my baby in his crib; that way he won't get into trouble." IV-102
    - 3.2.3 "I talk to my baby while he is eating." IV-103
  - 3.3 Attitudes and knowledge of child development IV-104
    - 3.3.1 "As long as you take basic care of your baby, for example, feed and clean him, he should turn out just fine." IV-106
    - 3.3.2 "Most babies of a particular age are pretty much alike." .. IV-107
    - 3.3.3 "Babies can't learn much before the age of one." IV-108
    - 3.3.4 "Babies of about a year and a half aren't interested in books. They just tear them." IV-109
    - 3.3.5 "Being a good mother is a really important job." IV-110

TABLE OF CONTENTS - (continued)

PAGE

3.4 Summary of parenting attitudes, behavior and feelings IV-111

CHAPTER V - SELF-CONCEPT

1.0 Description of items............................ V-1
2.0 Changes over time in self-concept V-4
    2.1 Changes in general outlook V-4
        2.1.1 "You can trust most people" V-5
        2.1.2 "The future looks bright for today's children." V-5
        2.1.3 "My children are going to have a lot more than I do." V-6
        2.1.4 Summary V-7
    2.2 Changes in feelings of social isolation V-8
        2.2.1 "I feel all alone in the world" .V-9
        2.2.2 "I need to be with people." V-9
        2.2.3 "I tend to feel shy with people." V-10
    2.3 Changes in feelings of personal power, competence and control V-12
        2.3.1 "What happens to me is my own doing." V-14
        2.3.2 "When I make plans, I am pretty sure they will work." V-14
        2.3.3 "I don't like to make decisions" V-14
        2.3.4 "There's not much I can do to change the way things are." ... V-15
        2.3.5 "Doing anything about a happier future is just a waste of time" V-15
        2.3.6 "There's no use in planning for tomorrow; all we can do is live for the present." V-16
        2.3.7 Summary V-16
    2.4 Changes in involvement in community affairs V-17
        2.4.1 "I vote in local and national elections." V-18
        2.4.2 "I get involved in community affairs." V-18
        2.4.3 "I talk to others about the needs of this community." V-19
        2.4.4 Summary V-20

CHAPTER VI - KNOWLEDGE AND USE OF COMMUNITY RESOURCES

1.0 Introduction VI-1
2.0 Membership in community groups VI-1
3.0 Number of respondents and/or spouses taking courses and level of these courses VI-5

TABLE OF CONTENTS - (continued)

PAGE

4.0 Knowledge and use of available community resources VI-10
  4.1 Basic supportive services VI-13
    4.1.1 Knowledge and utilitzation of food stamps VI-14
    4.1.2 Commodities VI-17
    4.1.3 Medicaid VI-20
    4.1.4 Welfare VI-22
  4.2 Medical facilities VI-25
    4.2.1 Health center or clinic VI-25
    4.2.2 Public hospital VI-27
    4.2.3 Mental health clinic VI-30
    4.2.4 Family counseling agencies VI-33
    4.2.5 Planned parenthood services VI-37
  4.3 Early childhood programs VI-40
    4.3.1 Head Start VI-40
    4.3.2 Day care or child care programs VI-43
  4.4 Free legal services (Legal Aid) VI-45
  4.5 Housing Authority VI-48
  4.6 Resources related to employment VI-50
    4.6.1 State employment office VI-50
    4.6.2 Job training program VI-53
5.0 Summary VI-55

CHAPTER VII - HEALTH AND NUTRITION

1.0 Overview VII-1
2.0 Health care VII-1
  2.1 Pre-natal care VII-1
  2.2 Immunizations VII-6
  2.3 Medical check-ups VII-13
    2.3.1 Check-ups during the first year of life VII-14
    2.3.2 Check-ups for the child between 1 nad 4 .... VII-16
    2.3.3 Annual examinations for other family members VII-18
  2.4 Dental check-ups for family members . VII-19
    2.4.1 Dental check-ups for respondents VII-19
    2.4.2 Dental check-ups for children VII-20
3.0 Nutrition VII-21
4.0 Summary VII-23

CHAPTER VIII - THE IMPACT OF PCC: SOME FINAL THOUGHTS

CHAPTER I

INTRODUCTION

The Parent-Child Center (PCC) program was initiated in 1968 as a national demonstration which grew out of the recommendations of the 1966 White House Conference on children. The program is administered through Project Head Start, initially under the aegis of the Office of Economic Opportunity, now under the Office of Child Development (OCD). Designed for families whose incomes fall below the Federally-established poverty levels, the program focuses upon meeting the needs of children from the time of conception to age three, and the needs of their parents. The formal PCC objectives established at the national level, are as follows:

1. Overcoming deficits in health, intellectual, social and emotional development, and maximizing the child's inherent talents and potentialities;

2. Improving the skills, confidence, attitudes, and motivations of the parents as citizens;

3. Strengthening family organization and functioning by involving the youngest children, the parents, older children in the family, and relatives;

4. Encouraging a greater sense of community and neighborliness among the families served by the Center;

5. Providing training and experience for both professionals and nonprofessionals who may then be employed in work with parents and children;

6. Serving as a locus for research and evaluation of progress toward the objectives stated above.

There are thirty-three PCCs located throughout the country in urban and rural areas. The locations of these programs are listed below:

Urban

Los Angeles, California
Oakland, California
Washington, D.C.
Jacksonville, Florida
Atlanta, Georgia
Honolulu, Hawaii
Chicago, Illinois
Louisville, Kentucky
Baltimore, Maryland
Boston, Massachusetts
Detroit, Michigan
Minneapolis, Minnesota
St. Louis, Missouri
Omaha, Nebraska
Newark, New Jersey
New York, New York
Cincinnati, Ohio
Cleveland, Ohio
Philadelphia, Pennsylvania
Chattanooga, Tennessee
Dallas, Texas

Rural

Hoonah and Kotzebue, Alaska
La Junta, Colorado
Dalton, Georgia
Summerville, Georgia
Mt. Carmel, Illinois
Leitchfield, Kentucky
Pine Ridge, South Dakota
Fayetteville, Tennessee
Barton, Vermont
Pasco, Washington
Huntington, West Virginia
Menomonie, Wisconsin

By 1968, experience with Head Start had suggested that low-income children are already at a disadvantage by the time they reach Head Start age. The PCC program reflects this experience, and the view that intervention should begin at birth or, preferably, at conception if the pattern of deficit and under-achievement is to be avoided.

As ideally conceived, PCC, is to deliver and/or coordinate the delivery of comprehensive services to children 0-3, and to their families. Each Center is supposed to deliver education services to 100 children, either in-Center or in an outreach home-based program. In addition to the education component for parents and the education component for children, PCCs have a health component, a nutrition component, and a social services component.

A very strong emphasis is to be placed on parent participation and parent education, because it is hypothesized that children's gains will not be sustained unless accompanied by changes in parenting behavior. Thus, a parent education component with focus on child development, on health care and nutrition, and on home management, is a mandated aspect of every PCC. Parents are expected to attend the PCC with their children, and to participate in the classroom with their children on a regular basis. The PCC is not intended to function as a child day care center. Rather, the PCC is conceived as an effort to strengthen parents in their parenting roles: to enable and to facilitate, rather than to substitute for parenting. Moreover, it is mandated that parents must have a major say in the direction and shaping of each project at the local level. Each PCC is supposed to have an active Policy Advisory Council (PAC), comprised of at least 50% participant-parents, which acts as the governing board of the PCC.

Almost inevitably, "ideal" programs conceived at a national level are individually molded at the local level, in response to local needs and constraints. The PCCs are no exception. PCC Directors and Boards vary widely in the extent to which national guidelines provide a framework for operations. Some are very concerned with the PCC concept and are very conscious of the guidelines, others are more concerned with running a program at the local level, and are less concerned with PCC as a national demonstration program.

For example, the genuine participation by parents has proved to be a very difficult goal to achieve at most Centers. Thus, while parent participation is central to the PCC concept, PCCs vary widely in the extent to which such participation has actually been acheived. At some Centers, the majority of the parents do spend at least a few hours each week at the PCC in education related activities. However, this involvement does not necessarily include classroom participation in child education related activities, as originally planned. At the majority of Centers in which there is participation by parents it is usually in the form of seminars or informal discussion groups dealing with child-development, health, nutrition, and home management. Parents rarely work with their own children in the classroom. There are relatively few Centers at which parents work in the classroom with children, in a supervised setting where a teacher actively interprets to them what is being done with the child and why, and encourages the parent to try various activities designed to promote specific aspects of the child's development. That is, most PCCs do not provide a practicum experience for parents in child development.

Some PCCs require that parents participate in parent activities. At these Centers, parents who do not participate are contacted either by staff or by other parents to determine the reason for non-participation. Attempts are made to help with whatever conditions are preventing participation; unmotivated parents seeking a baby sitting facility are dropped from program.

Other PCCs do what they can to motivate their membership, but do not require participation. The rationale is generally that non-participating parents have serious life problems which prevent their participation in education related activities and it would not be in their best interest or in the childrens' best interest to drop them from program. Consequently, a large proportion of parents at these Centers do not participate in PCC related activities. Their children come to the Center without their parents, they are taken care of by PCC staff, and only a small minority of parents attend group discussions and seminars. This type of conflict between PCC as a demonstration program and PCC as a program which serves low income families is seldom recognized, and even more rarely given overt expression.

It should be made explicit that the present evaluation is based on the national program as it exists, and can in no way be taken as an evaluation of the Parent-Child Center concept, per se. An evaluation of the latter would have called for a very different research strategy in which the impact of program on parents would be investigated only among those parents who actively and regularly participate in activities designed to promote the development of their parenting skills. As will be clear from the design of the study presented in Chapter II, the parent sample is drawn from a representative sample of Centers. At several of these Centers, parents do not participate in educational activities with their children, and their participation in any kind of PCC activities is minimal. Even within Centers where parents do participate, the scope and nature of participation varies widely. In light of these considerations it is apparent that the evaluation can make little contribution to the basic hypothesis underlying the formation of the Parent-Child Centers, i.e., that an educational program which stresses child development and provides a practicum in infant and toddler care and education can enhance and promote parenting skills. The evaluation does address itself to the impact of the national program as it is implemented, on a representative sample of parents from a representative sample of Centers.

Explicit parent education models have not been developed and there seems to have been little opportunity to test out specifically the relative efficacy of one parent education model versus another. Professionals in parent education agree that the most effective training methods include demonstrations, practicums, and other participatory activities, rather than non-participatory methods such as lectures. However, due to the difficulties of obtaining parent participation in the classroom, most Centers treat child development in a more didactic manner.

Diversity of approach, not only to parent education but to all program components, is the hallmark of the PCCs. This is true not only among PCCs but also within PCCs within a given year. A planned variation approach would be useful for determining the relative impact and the trade-offs of various approaches, but the PCC program has not yet developed such an approach.

The national guidelines stress parent education, the enhancement of parental confidence, and knowledge and use of community resources. Some programs have a greater emphasis on the education component and others on the social service component. The latter function in many ways as settlement houses with an early childhood component. In other words, they are conceived of as a friendly, comfortable environment in which parents congregate, socialize, and from which occasional referrals are made to various social service and health agencies.

In these programs, the feeling is that the parents can best be helped to help their children through a program designed to improve their feelings about themselves and through the provision of supportive services. It should be stressed that in terms of actual program operations, Centers do not utilize an either or approach; rather the question is one of relative emphasis.

Just as the national PCC program has developed no consistent approach to parent education and no consistent policy regarding parent participation, so there has been no consistent approach to childhood education. Several programs use a structured or carefully sequenced cognitive approach while the majority rely on a developmental affective approach. Similarly, most PCCs do not make explicit, and tend to avoid definition of what they consider good parenting. For example, in some programs even long-term parents are clearly punitive and threatening in their interactions with children, yet staff members do not intervene with an alternative approach. In some other programs, parents are never or rarely seen interacting with their children, so that staff are not in a position to focus on parental style and approach.

The Policy Advisory Councils range from being rather ineffective to being mature boards which have a major input into personnel practices, budget allocation, and program direction.

Case studies of the seven sample PCCs were presented as Volume I of the interim impact report.[1] These case studies were written at the time of initial data collection in September and October of 1972. They were intended to demonstrate the range and diversity of the programs represented in the study, and to provide a background for understanding the summative data. Return visits to the sites 9 months later show the tremendous changes which occur within individual programs during a program year. Two of the programs moved to different quarters with inescapable effect on program, and two additional programs radically restructured their entire operations. Only three of the programs remained relatively stable in both operations and participants. Consequently, the evaluation is of the impact of an input which is often intense, well-meaning, and dedicated but which is often non-specific and changeable in its operations and objectives. In a sense the realities of the PCC program are such that it has not achieved sufficient stability to warrant an impact study: in many ways it would be more fruitful to view the PCCs as a program still in its formative phase. Since several of the earlier case studies are outdated and in order for the reader to have a picture of the programs and the different inputs which they provide, a relatively brief description of each program is provided.

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[1] Volume I: Case Studies of the Seven Parent-Child Centers Included in the Impact Study

Particular emphasis is placed upon making explicit the changes which have occurred over the program year.

PCC 1

This urban PCC is located in a southern community. The catchment area around the PCC has a suburban look; the gardens and lawns surrounding the 1 & 2 family homes make the area more attractive than that surrounding inner-city PCCs. The Center serves 60 families, all of whom are black. Thirty-eight of these families are on welfare; only 6 are intact. There are 16 people on staff; one half of whom are professionals. Three of the staff are parents. The present Director has been with the PCC nearly 3 years. The Center has had only 1 previous Director. Staff turnover during the evaluation year has been negligible; prior to that time there was considerable turnover of staff in key positions.

During the course of the evaluation year, this PCC moved to new quarters. Unlike the previous facility, the new one gives the PCC more than adequate program space.

There are 4 groups of children who come to the Center 5 days a week for four and one-half hour sessions each day. The children range in ages from 2 months to six years. This community has no Head Start program, therefore the PCC age range has been extended to six year olds. Home visits are available to families with infants. At the time of the T1 visit families with children under the age of one were being

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The emphasis at this Center tends to be on cognitive learning. In the younger children's programs, language development is greatly stressed. Careful records are kept on the number of words learned by children in the one-two year old group, and are then compared to established norms for children of that age. Age groupings are flexible and depend more on developmental skills than on chronological age. Older children's programs are conducted in a school-like atmosphere. Children raise their hands to be recognized and spend a good deal of their day seated around the table engaged in structured group activities. As this community is not served by a Head Start, children in this group will be moved directly from the PCC into the school system. These children are learning early to behave in a manner that is consistent with the expectations of a classroom.

The parent education component of this PCC provides an active, well-implemented program for which participation requirements are stringent. First and foremost is the requirement that each parent, in order to maintain her child's enrollment in the PCC, must attend sessions three days per week. Parents who do not participate regularly are seen by the Family Service Coordinator in an effort to understand what is impeding participation. If non-participation continues, the family can be terminated upon the decision of a committee comprised of parents and staff.

A technical school in the area offers a series of three consecutive courses, at the PCC, in child development. Each course represents 60 hours of work and the three courses take one year to complete. A practicum, in which most mothers spend two weeks during the year in one of the children's room, is considered part of the child development course.

In addition to this course, parents participate in numerous activities around arts and crafts and home decoration. Parents who wish to further pursue any activity can come into the Center on the two non-structured optional days to work on their own projects. Nutrition is pursued as a topic for several months during the year in addition to consumer education, budgeting and home management. Other discussions are led by the Parent Educator around such issues as civic responsibility, the role of women, and the black heritage.

As there is no nurse the Social Service Component assumes the responsibility for making referrals to medical resources, for maintaining health records, and for ensuring that all PCC focal children have immunizations, sickle cell tests and routine check-ups. These responsibilities are in addition to those of recruiting and interviewing new families and visiting mothers who are not meeting their commitment to participate in program. While some minimal counseling is done by PCC staff, most problems of this nature are referred to agencies which specialize in counseling services.

PCC 2

This PCC is situated in an urban community. The catchment area, with a large number of burnt out, abandoned, vandalized houses, is surrounded by recently built luxury housing. Inside the catchment area, there is an enclave of well-kept mansions on wide gas-lit streets. The PCC operates within an approximately two square mile area, the borders of which give no indication of the poverty that lies within.

The Center serves 78 families, 77 of which are black. Fifty-four of these families are on welfare; twenty are intact. The staff numbers 21 individuals including two part-time parent substitutes and a part-time social worker. Four of the staff are professionals; two are parents. All of the non-professional staff have been given scholarships to attend classes at community colleges as of May, 1973. There has been no staff turnover during the time frame of the evaluation and in general there has been very little turnover in this PCC. The present Director has held this position for approximately 2 years and prior to this served as the Center's Child Development Trainer.

There have been no major program changes in the PCC since the fall, 1972 visit. However, alterations in the classroom facilities have precipitated small changes. The children now have all sessions in a mobile unit located on the grounds of an elementary school. The site is several blocks from the PCC. The two-room mobile unit consists of one room designated for gross motor activities and one for fine motor activities. Activities are planned simultaneously in both rooms so the children can choose what they would like to do. There are 3 groups of children, each coming for two sessions a week. Each session lasts two and one half hours. Since there are no kitchen facilities at the classroom, food for the children is brought over by van from the PCC building.

The infant room is seldom used. PCC staff has tried to get parents with infants into the Center once a week but so far has been unable to accomplish this goal.

Sessions at this Center are relatively unstructured with emphasis on the acquisition of social skills. A lesson plan is devised for each session, but the children structure the session more than does the plan. The children play well together and seem most interested in each other. Parents were not seen in the classroom and this is not common practice.

A full, hot lunch is served, in addition to a snack, during each session. Children wash before lunch, recite a short prayer, and then sit down to eat.

Other reorganization that has occurred has been in the facilities for parent education and social service. The first floor of the PCC, formerly used for children's classrooms, has been turned over to the parents for meetings and for a babysitting area while the parents are busy upstairs. When the parents meet, the Social Service Staff is in charge of babysitting. During these times there is no structured program of activities for the children. The staff is trying to find parents interested in volunteering as babysitters.

The Parent Education Component has been intensified with more committees and groups meeting to plan community projects and to hold discussions. Local college students teach weekly sessions in nutrition, home economics, and sewing. Money is being raised to send parents, who wish to attend, to school. Parent participation is not mandatory. There is a core group of parents who plan activities and participate in PCC sponsored programs. The majority are not really active and regular participants.

The PCC Nurse is responsible for making sure that all children have appropriate check-ups and immunization. She has received clearance to administer measles immunizations and tuberculosis tests at the Center. Also, PCC has arranged for vision, hearing, and dental screening for children who will be graduating from PCC this summer.

PCC 3

This urban West Coast PCC, is located in a suburban looking area. Housing in the catchment area is composed of a large, public housing project, private homes, motel-like apartments and modest frame and stucco structures. A large naval base and the nearby port provide the community with some employment opportunities, but primarily with poorly paid jobs which are filled by transients who live in the area while stationed at the base.

The Center serves 100 families, 43 of whom are Mexican-American, 20 are black, 12 Puerto Rican, and 13 are Polynesian. Fifty-two of the families are on welfare; sixty-one of the families have a father living in the home. There are fifteen people on staff, of whom 3 are professionals and none are parents. The present Director has held his position for approximately 1 and 1/2 years. He is the third person to hold this position. The Education Coordinator and the nursing aide, the only 2 members of the child education component, terminated their employment during the course of the evaluation year.

Children come once a week for a three hour session. Although the program serves children from birth onward, no age appropriate toys for infants are in evidence. Unlike several other PCCs in the sample, the infant program is not really viable.

Older children participate in a rather typical nursery school program. They engage in small group lessons, they have free play in the housekeeping corner, the painting area, or the book corner, or they play outside.

Parent education at this PCC is minimal. In the past there was a sewing class, a nutrition session, a consumer education course, a fathers' group and a class called "English as a Second Language"; currently there is a small fathers' group and a physical fitness program. Parents rejected the other classes and have not been motivated to involve themselves in the childhood education classes. They do not attend children's sessions nor do they readily volunteer to be trained for the positions of babysitter and nursery parent aide. Training sessions for these positions are held once a month and parents attending are eligible to be called upon to fill these slots on a rotating basis and to be paid for their efforts. The small core of parents who are trained fill these positions as needed.

While the majority of parents do not participate in structured educational activities, some come to the PCC almost daily. For many parents, the PCC provides a friendly setting in which adult companionship and babysitting services are regularly available.

The real thrust of the program is the Social Service Component. It is the largest program component, staffed by six Community Service Workers (CSWs) and a supervisor. Each PCC participant is assigned to a CSW who becomes her primary contact with the Center. Frequent home visits which serve to provide support and referral information are made to each family. In addition, one evening per month each CSW chairs a meeting for all of her families in order to review the months' events. Currently, the CSWs are conducting nursery sessions as well.

The Parent-Child Center offers a wide reaching, comprehensive medical plan to its participants. Initially the program's affiliation with a nearby clinic-hospital was used by the CSWs as a means of recruiting new families. While the Director reports that this is no longer the case, health care still remains a prominent "selling point" in the eyes of PCC parents.

PCC 4

Until June of this year, this PCC was operating in four sites, widely spread apart, in the rural midwest. The area is sparsely populated; dotted with small towns, many of which are so small they are unincorporated. Agriculture is the primary occupation although the farms are not as rich as they once were. The PCC population, before June, included a large number of American Indians.

In June, 1973, just before the visit by CCR, this PCC closed two of its sites. The two sites which had fewest families were closed and a third site was moved a few miles, in order to lessen transportation costs, into a building already housing the Head Start program. Since they serve the same families the PCC is able to share a bus with Head Start. The northern most site, which was closed, was situated on an Indian Reservation. Now although there are still American Indians enrolled in the program, their number is far fewer.

Currently the two sites serve 67 families with a total of 78 children 0 - 3. Forty-eight of the families are classified as other Caucasian, 18 are American Indians, and 1 is Mexican-American. Twenty four families receive welfare assistance; twenty one families have female heads of households. There are twenty nine staff members, including four VISTA volunteers. Nine of the staff are professionals; half of the non-professional staff are PCC parents. The present Director, the fourth that this PCC has had, has been with the program just under two years.

At each site children attend programs 2 days each week for four hour sessions. There is a very active infant group, a toddler group, and a runabout group.

At both sites the facilities for children are especially well planned. Infant rooms are well designed with low hung mobiles locally made busy boxes, floor length mirrors, and huge stuffed animals for reclining and cuddling. Older children's rooms are divided into four areas: housekeeping, art, story-telling, and motor development. Drawings of animals are placed at the childrens' eye level; portions of these are textured so that there is something for the children to touch on each animal.

The children's program relies on a structured sequenced approach; particularly in the infant program individualized objectives are developed for each child. The children's component is well organized and richly varied both in terms of equipment available and the uses to which it is put. Unlike most Centers, there are two child development specialists at each site: one for infants and the other for older PCC children.

There is an effort at this PCC to involve parents directly in the children's classrooms but these parents who live in an isolated rural area and rarely have the opportunity outside PCC to socialize with others prefer to spend their in-PCC time meeting with other parents. In an effort to involve parents in children's activities, PCC staff has instituted a Home Intervention program. To begin, Child Development Aides and teachers will choose one family with whom they feel they have good rapport. Once a week, a staff member will visit the family at home and prescribe and demonstrate tasks for the parents to teach their children. The mother will be shown how to keep daily activity charts so she may better see her child's progress. The Home Intervention program has recently begun at one site; it has yet to start at the second site.

While parents have not participated in the children's classrooms they have been involved in a variety of other activities. Parents are expected to be at the Centers on the two mornings that their child are at the Center. The emphasis in the parent program is on home management,including home repairs, health, nutrition, and child development. Large numbers of pamphlets are made available and discussed; outside speakers and films are a regular part of the program.

The VISTA nurse spends two days a week at each Center teaching health care to parents.

Medical appointments are coordinated through the PCC which also provides transportation. A VISTA dentist who works in a mobile unit on the grounds of one of the PCC sites services families from both sites.

Parents receive a hot meal on the two days they attend program, as do the children.

PCC 5

This rural PCC serves a five county catchment area. Although the predominant industry is agriculture, the wealth of the community stems from oil and a newly burgeoning coal mining industry. While new jobs may become available as a result of this growth in mining, at present, unemployment in the counties is high.

The Center serves a total of 52 families, all of whom are Caucasian. Twenty two of the families are on welfare; 18 are households which are headed by a female. There are twenty five people on staff, seven of whom are parents and none of whom is a professional.

Until just prior to the evaluation year, there had been marked staff stability at this PCC. Just before the first evaluation visit the Center lost a Director, an Assistant Director, an RN, an Early Childhood Coordinator, and a Data Coordinator. During the course of the evaluation year the Director and nurse were replaced while the responsibilities of some of the other positions were shifted to other staff members.

Families served by the outreach program are seen once a week, for one hour at a time. The aim is to work with the mother in order to teach her to be the teacher of her child. Notes are kept on each child on a visit-by visit basis so that the worker going into the home knows exactly what must be stressed. Mothers are shown what work to do with the baby and how it can be done. In addition, numerous toys are left at the home so that mother and child can perform the appropriate tasks. Children living in the Center's catchment area who are 0-6 months of age or 3-5 years are also eligible for outreach. Older children receive this attention because a Head Start program is only available to them during the summer. Children in the In-Center program attend five hours a day, 4 days a week.

The In-Center program follows a curriculum of sequential learning. It delineates developmental milestones which should be achieved at each level of development and tasks which are to be used to promote this growth. The nursery staff, most of whom are mothers, has an awareness of each child's present abilities and the objectives that are being worked toward. Notes are kept on every child's progress and parent and teachers spend time each session discussing what should be done to stimulate further development. There is a large and very active infant program in which activities for infants are well and carefully thought through and implemented.

Each mother is expected to spend one full day a week in the Center working within the classroom. During this time the mother works with her own child receiving instruction and aide from the teacher. In addition, all mothers must spend a week in the classroom several times a year serving as an aide, "mother of the week."

In the four outreach counties, there is a parent meeting once a week. Participation and attendance are generally high. These meetings provide information on child development, home management, crafts, etc., in addition to allowing parents the opportunity to mingle with other adults, an important social activity that is often lacking in rural communities.

Health and social services are handled on a referral basis. As most of the outreach staff share office space with rural resource personnel, referrals are promptly effected. Nutrition and nutrition education are an important aspect of program. Children receive daily vitamins, as well as breakfast, a full lunch and an afternoon snack. Nutrition education sessions for parents focus upon such matters as proper budgeting, economical purchase of food stuff, food storage and preparation. Such sessions are often part of the weekly parent meetings.

PCC 6

A rural PCC, this program serves Mexican Americans primarily. The PCC is situated in one of the largest crop growing valleys in the U.S. Most of the PCC families are seasonally employed farm workers who do not migrate from place to place. Extensive collateral family ties, a good climate, and immensely productive soil which allows families to be gainfully employed for 6 months of the year means that the devestating poverty seen in other rural areas is generally absent.

The program is maintained in two sites, 18 miles apart. During the fall of 1972 visit, the combined sites provided day care to 119 children. During the winter months the program operated 7 hours a day, five days a week. In the summers, to accomodate the crop picking families, the program operated 12 hours a day, five days per week. The present Director of this PCC was relatively new to the program in the fall of 1972, and was totally dissatisfied with the day care aspects of the operation. He felt that the use of the Center by parents as a place to leave their children for 12 hours a day was subverting the PCC concept. He felt that no meaningful parent education could take place and that staff training was also minimal because of the 60 hour work week. Based on these conditions, as well as on the loss of the facility in one of the sites, the entire program has been restructured.

As of May, 1972 when final impact data were collected, the program at one of the sites had become a home visiting program. Mothers and children are visited in the home twice a week for an hour each visit, on two consecutive days. During this time teachers play and work with the child in his mothers' presence. The mother is encouraged to participate and to try out what the teacher is doing. Several visits by the teacher were observed, and the enthusiasum of the children as they raced to meet the car as it pulled into the driveway and the extremely warm and collaborative relationship between teacher and family were all noteworthy. The extended family ties in the community mean that, often, a visit to one child becomes a visit to several children, as cousins and neighboring children pour into the house to see what is happening. The problem of the summer months has not really been resolved, in that most of the mothers work and therefore are not available for home visits. Attempts are made to visit and work with the children, as a substantial number of them are placed in PCC Day Care homes. These are homes which take in up to 6 children during the summer months. Liscensing has been obtained with PCC intervention and PCC provides some material, menus, and supervision to the homes. Essentially, the homes are limited in terms of the educational experience they provide, but they can be seen as an improvement over the alternative of leaving small children in cars all day while their parents pick the crops.

The second site had been closed for a month prior to the site visit and was in the process of reorganization. The plan is for children to attend the Center for two, two hour sessions each week.

Health and nutrition services are provided by an LPN and a nutrition aide at each site. Children in the home visiting program are brought into the central office for yearly check-ups, and immunizations are obtained through a local clinic. Referral and follow-up is performed by the nurse at each site. Special medical problems, if noticed by the teachers, are brought to the attention of the nurse who conducts home visits. Teachers are so busy focusing on the educational component that they tend to be relatively unaware of such issues as whether or not the children have had a dental check-up and special medical problems.

A social service component is staffed by an MSW and an aide. Both of these individuals had just been hired and the component is not fully implemented although the intention is to work toward developing a referral network and toward coordinating whatever community services are available.

The major thrust of this PCC is to offer a mechanism for quality childrens' education, and to provide parents with a practicum in child development. Through liaison with other community resources, continuing adult education, English as a second language, and GED classes are also offered. In the past this PCC has been staffed largely by parents; however, the present direction seems to be toward professionialization. A child development Coordinator had just been hired to work with the program. To date, the program for children can best be described as a warm supportive and friendly environment in which children and adults play together with considerable enjoyment. Neither the curriculum nor the approach could be described as sequenced or structured.

The Policy Advisory Council of this Center is small and does not seem to be a major force in decision making aspects. Most of the program direction seems to be provided by the Director and the Assistant Director.

The evaluation of impact at this Center offers major problems because of the variability of the input. If parents and children at this Center contributed to overall impact findings it is not at all clear as to which aspect of program made the contribution. Moreover it is entirely possible that the old program had impact on one set of variables, while the new program has impact on another. For instance, parents may feel more in control of their destiny because they are offered long hours of quality child care while they are working, but they may have increased awareness of parenting skills as a result of watching a teacher work with their child.Unfortunately, these hypothesis cannot be tested under present conditions of change and sample attrition.

PCC 7

Since the fall '72 visit, this mid-western urban PCC, has moved into new facilities. The catchment area remains the same but the PCC is no longer situated in the center of it. After the beginning of the year, the PCC moved to a very large building on the edge of the catchment area, closer to new high-rise apartments than to many of the families it serves. Evidence of the poverty of the catchment area can be seen on the main street in the area; store after store is abandoned and boarded-up or in a state of acute disrepair.

Currently the Center serves 72 families with a total of 94 focal children, all but one of the families is black. Forty-eight of the families are on welfare; thirteen are intact.

There are twenty one staff members. Four staff members are professionals, including a half-time nutritionist. Four of the staff are PCC parents. The present Director has been with the program nearly two years.

This PCC has two types of childrens' programs. One program consists of six daycare homes operated by the PCC five days a week, 8 hours a day. Formerly there were nine such homes. Each home has 3 children; the mothers of these children are employed. The daycare mothers receive training from the Child Development Worker once each month and this same staff member visits each home once a week bringing lesson plans and materials. One of the daycare mothers is enrolled in the PCC and another is the grandmother of a PCC child. In addition to the five sessions each week, the children and their natural parents come into the Center every Saturday morning for a two and one half hour session.

In the second type of program, children come to the PCC once a week for two and one-half hours. In addition, a staff member visits each family at home once a week for one hour. Infants under six months of age are seen in outreach only once a week.

A lesson plan is developed for each session with stress placed on numbers, colors, motor coordination, and language development. The greatest emphasis seems to be on language development. Conversation between teacher and children tends to be polite and formal. Children are praised verbally, but there is a marked absence of physical contact.

Parents are required to come to the Center on the one day that their children come. Part of the time parents are at the Center is spent in discussion groups and meetings with staff and other parents. As soon as the parents arrive in the morning they meet with staff to discuss the lesson plan for the day. Then they go into the classroom and work with the children. This is a new addition to the PCC parents program; at the former building there was no room for this type of activity. Thus, whatever impact there may be on parents from this Center as a result of direct participation with the children is not within the time frame of this evaluation since it represents a new innovation.

The Nutritionist, hired in spring, 1973, is planning to offer nutrition education and the Nurse, is planning health education sessions for parents. Evening programs for parents include classes on family planning, first aid, and early childhood diseases. While previously only a minority of parents had any real PCC involvement, currently a major effort is under way to motivate parents to participate in the parent education program.

Medical and dental services are available through the delegate agency's Comprehensive Health Center. All medical records are kept at the PCC as well as at the Health Center. Transportation to the Health Center is provided by the PCC van.

As can be seen from these descriptive reports, the sample Centers vary in terms of who is served, what is offered, frequency of service, and staff. The PCCs in the sample serve from 52-100 families. In some Centers all the families are Black, in others all are Caucasian and in still others there is a marked ethnic mixture. Children at these Centers are seen between 2 1/2 hours and 22 1/2 hours a week depending on the particular Center. In some the majority of families are seen only in the Center, in others the emphasis is on a home visiting program. PCCs vary in the degree to which there is a major emphasis on infants and in the extent to which there is an individually sequenced program. Requirements for parent participation vary, as does the extent to which parents are visible in program activities. Staffing patterns vary from 1 PCC in which half the staff is professional to another which has no professionals on staff. This individuality should be kept in mind during a review of study findings.

CHAPTER II

METHOD OF PROCEDURE

1.0 The strategy underlying the evaluation design

As with any evaluation, there were many strategic choice points during both the planning and the execution of the study. To promote an understanding of the final design, the more important of these choices are discussed below:

- Evaluation of the national program as implemented, rather than of those programs and parents which most nearly exemplify the PCC concept. This decision has already been discussed in Chapter I.

- Evaluative focus on parents rather than on children. OCD staff chose this focus both because early visitors to the PCCs seemed to feel that perhaps the greatest impact was on parents, and because earlier evaluations of pre-school intervention programs have suffered from an all-too-narrow focus on cognitive development of children. The conceptual thrust of the Parent-Child Center program is to provide services and education to parents in order to enhance their parenting role.

Hence, impact on parents is the most important aspect of the evaluation.[1]

- A repeated measurement design with each subject acting as his own control rather than a control group design. Selection of non-PCC subjects in a catchment area adjacent to the PCC would be subject to great sampling error unless the sample size was very large. Comparability of communities and services available would also be a considerable problem. In addition, problems of eliciting cooperation among non-PCC parents would be monumental. The selection of a control group within the catchment area was precluded by considerable data which show that joiners and eligible non-joiners are very different in their motivational and interpersonal resources. Since by and large, PCCs do not maintain waiting lists, comparisons among PCC newcomers and oldtimers, and among the newcomers themselves, over time, provide the most methodologically sound approach.

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[1] Children's data are being collected by PCC staff at 14 Centers. These findings are the subject of a separate report on PCC impact on children. As a brief summary, it can be stated that all children at the 14 PCCs between the ages of 3.0 and 4.11 have been tested on the Pre-School Inventory and on the Denver Developmental Screening Test. Performance of PCC children is compared with normative data for non-PCC children. While the level of performance of PCC children cannot be directly attributed to PCC, the data provide a picture of how these children are functioning in a number of important areas. Pre-post comparisons with children are not possible because most of the differences in young children over a one-year period would be attributable to maturation rather than to program.

Once the decision had been made to conduct a national evaluation of the impact of PCC on parents in a repeated measurements design, certain steps were taken to ensure that impact data would be collected at a representative sample of Centers. Phase I of the study was designed to ensure such representativeness.

2.0 Phase I

During Phase I, CCR staff conducted on-site interviews at 32 of the 33 PCCs with PCC staff and with a sample of parents at each Center. These interviews were conducted between October 1971 and January 1972. Ultimately, 327 staff and 385 parent interviews were conducted. These interview data dealt with PCC objectives, staff organizations, education programs for children and parents, health, and social services; they were then used to cluster the Centers into five groups.

The process used to cluster the Centers is presented in great detail in an earlier report[1] and will be only briefly recapitulated here. Initial attempts included several computer runs seeking to cluster interval data. Three separate attempts to cluster along important variables: e.g., ratio of professionals to paraprofessionals, style and continuity of leadership, hours per week per "average" child, orientation of children's program, education vs. social work emphasis of the program, only seemed to demonstrate that clustering along empirical dimensions was impossible due to the highly individualistic nature of the Centers.

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[1] Clustering and the Selection of a Representative Sample of Centers

From a program point of view, the uniqueness of each Center makes for a great richness of experience. From an evaluation standpoint, that uniqueness does not permit clustering along more than a few dimensions. Attempts to cluster according to program emphasis and according to the relative strength of various program elements also failed. The former approach did not discriminate adequately among clusters, and the latter approach led to groupings of "good" vs. "bad" programs rather than to general models which included similarly oriented Centers.

Analysis of all the data suggested that there were three fundamentally different approaches to parent programming and two different approaches to childrens' programming. It is on the basis of these underlying themes that the Centers were finally clustered.

The three approaches to parent programming are:

- The enhancement of parenting skills, shown by an emphasis on instruction in child development and home management skills. The primary thrust of these PCCs is to teach mothers to better fulfill their roles as mothers.
- The fostering or enabling of career opportunities either through an adult education emphasis, or a college affiliation, or through the provision of child care facilities which permit parents to hold jobs. A primary emphasis is on teaching child care skills which will enable parents to be gainfully employed either at PCC or in other preschool programs.
- The provision of a generally supportive environment with a view of the Center as a place to socialize and overcome parental isolation and a concommitent emphasis on the delivery of social services to promote well-being. The staff are seen by parents not so much as teachers, but rather as nurturant and supportive helpers.

The underlying theme of children's programming is two-fold:

- An emphasis on a relatively structured cognitive stimulation approach. Sequenced learning, an emphasis on individually tailored objectives, and infant stimulation, are the hallmarks of this approach. Models which emphasize a step-by-step developmental approach are favored.

- Emphasis on a general developmental affective environment for children. The thrust is to provide children with a warm, emotionally-supportive environment.

While, theoretically, each of the three parent-oriented approaches may be matched with each of the two children's orientations, no Center was found to provide cognitive stimulation to children and a generally supportive environment for mothers. The following five clusters were identified:

Cluster 1: Parenting emphasis for mothers, developmental-affective approach for children.

Cluster 2: Parenting emphasis for mothers, structured learning approach for children.

Cluster 3: Career emphasis for parents, structured learning orientation for children.

Cluster 4: Career emphasis for parents, developmental-affective approach for children.

Cluster 5: Supportive and socializing environment for parents, developmental-affective approach for children.

Initially, six PCCs were selected for impact study, one from each cluster and two from Cluster 1, after extensive discussion with the OCD Director of the PCC program, and the OCD Program Coordinators. The choice of specific PCCs within a cluster was dictated by several considerations. Programs were chosen to include representation of various kinds of home visiting models: i.e., home visits as a means of reinforcing the in-Center program or as a sole means of contact with families, home visits as an educationally-oriented experience for mothers and children or as a mechanism for social service delivery. Centers were also chosen to ensure representativeness along the urban-rural dimension. Centers were excluded from consideration if they had been selected as programs which were to have an Advocacy Component. The rationale was that the Centers were and would be different from other Centers because of the additional component and that they would no longer be representative of the national PCC program per se. Centers which had not demonstrated program stability over the previous six months were excluded in an effort to increase the probability that the sample Centers would continue in the orientation evident at the time of sample selection.

Unfortunately, as was discussed in Chapter I, program stability prior to the inception of an evaluation is apparently no guarantee of stability during the evaluation year. After the six sample Centers were selected, during data collection at T1, it became clear that one of the programs was going to undergo massive program changes and that a large proportion of the T1 sample would be likely to leave the Center before the scheduled completion of the evaluation. For this reason, a seventh Center was added, in consultation with OCD.

In this evaluation, no attempt has been made to test the relative benefits or impact from one cluster as opposed to another. Such an approach requires systematic variation between clusters, as well as an N of Centers sufficiently large to permit partialling out of different variance components. None of these assumptions is true. Centers within a cluster differ markedly from each other along many important dimensions and show areas of similarity with Centers in other clusters. Moreover, such an approach is costly and not warranted by the program because of the variability within clusters and the lack of stability. Such a design is warranted only in the case of a planned variation approach to program planning.

Since the thrust of the evaluation is on the impact of the national program as a whole, particular care was taken to maximize the chances that all major program emphases and styles are represented in the sample of Centers. As was discussed in Chapter I, the programs selected represent the full range of PCC variability. The programs range from all-day services to children to two hours a week per child; from eight hours a week of expected attendance by parents to zero hours; from home visits for all families to home visits to none; from programs in which a professional heads nearly every component to programs where the entire staff is non-professional; from programs with a primary emphasis on education to programs with a primary emphasis on social services.

Demographic characteristics of the sample of participants will be discussed fully in Chapter III. In the present context, it should be noted that comparisons between respondents at the sample Centers and the sample of participants at all 32 PCCs show no significant differences. Thus, the Centers selected for inclusion in the study are representative not only in terms of program, but also in terms of the kinds of families they serve.

3.0 Phase II

3.1 Impact dimensions

Once the representative Centers had been selected, the focus of attention shifted to the criterion dimensions for impact measurement. The OCD National Director of the PCC program and the OCD Program Coordinators met with the CCR staff to discuss areas of possible impact. Program staff were asked to address themselves to those areas of attitude and behavior in which they would expect to find changes in parents as a result of program participation. Emergent areas of measurement relate to the national objectives of the PCC program and to the components which are a mandated part of every PCC: parent education, social services, health, and nutrition. The areas of impact are discussed below:

- PARENTING

  It is clear that increased knowledge of basic child development and a more positive attitude toward the importance of the maternal role should be a result of the PCC experience. It was the consensus of the National Review Panel that it would be important to avoid such evaluative concepts as "good" and "bad" mothering. It was pointed out that the vast majority of mothers hit their children, shout, and act disinterested at times. While PCC might decrease instances of such behavior, it should increase the number of other options available to a mother in a given situation. The measurement and analyses of parenting behavior avoids pejorative judgements as to what constitutes "good" or "bad" parenting. Instead, measurement focuses on parents' ability to meet everyday child-rearing problems with alternative solutions, based on the realization that solutions are differentially effective, depending on the developmental age of the child and the motivation underlying the child's behavior. Six problem situations were posed, to which parents were urged to give as many alternative responses as possible.

These changes are expected to be related primarily to the parent education component.

Findings related to this dimension are presented in Chapter IV.

- SELF-CONCEPT

Much of what CCR staff heard from parents during Phase I interviews appeared to reflect greater self-regard. As an outgrowth of discussions with the PCC National Coordinator and with the Review Panel, it was decided to focus particular attention on feelings of personal control and the ability to influence events. Low-income parents are often discouraged and feel that things are so bad that nothing they can do will make a difference. The mutability of events and the concept that planning and personal effort can make an important difference, are cornerstones of the PCC concept. Thus, this becomes an important evaluative dimension.

Another aspect of self-concept involves the definition of self as a person worthy of regard by others. Throughout its four-year history, PCC staff and parents have commented on the increased sociability of the parents. Some parents in CCR's Phase I interviews described how, prior to the PCC experience, they were shy and had no friends. With considerable affect, they described the importance in their lives of friendships gained through PCC.

For the purposes of this evaluation, a person with a positive self-concept was defined as "someone who has a sense of himself as a likeable and competent person, with control over his own life."

These changes are expected to be related to the overall emphasis of PCC on the importance and worth of the parent as a human being.

Findings along this dimension are presented in Chapter V

- KNOWLEDGE AND USE OF COMMUNITY RESOURCES

It is an objective of every PCC to ensure that parents be knowledgeable about and actually use whatever resources are available in the community. This includes referral to and coordination with health facilities, public assistance, legal aid, and educational institutions. Thus, it was hypothesized that as a function of the PCC experience, parents would be more knowledgeable about available community resources and more active as consumers of community services.

These changes are expected to be related to the efforts of the social service component.

Findings along this dimension are presented in Chapter VI

- HEALTH AND NUTRITION

  It was expected that health care and nutrition would be more regular and more appropriate as a function of PCC participation.

These changes are expected to be related to the efforts of the health and nutrition components.

Findings along this dimension are presented in Chapter VII

3.2 Questionnaire construction

The review and ultimate rejection of existing instruments, the process of questionnaire construction, the rationale for item selection, and the pre-test at two non-sample PCCs, are all described in great detail in the Interim Report [1] on T1 findings and will be only briefly recapitulated here.

Review of existing instruments revealed no instruments suitable to measure certain of the constructs selected: i.e., parental ability to think of alternative ways of handling undesirable behavior, and knowledge and use of community resources. Instruments do exist which measure other constructs but existing scales of self-concept, feelings of competence, interpersonal engagement, and community involvement, are generally standardized on college populations. Many items are concealed in elaborate language, e.g., "we are all cogs in the machinery of life," which made them unsuitable in the present context. In addition, these scales tend to have a negative or apocalyptic tone which the pre-test showed as unsuitable for the present population, e.g., "I feel I am a person of no worth." Such items were found to be objectionable, and were rejected by PCC parents.

The pre-test was extremely valuable in that it enabled parents to comment on individual items and gave research staff a much clearer idea of which items would be acceptable and workable. Items found to be objectionable, incomprehensible, or which had poor item statistics, were discarded.

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[1] The impact of the Parent-Child Centers on Parents: An Interim Report. Volume II.

The final questionnaire consisted of a demographic section; a parenting section in which six problem situations were presented and parents were asked to develop alternatives,as well as 11 Likert items designed to measure parenting behavior and attitudes; a set of 15 likert items designed to measure self-concept, feelings of social isolation and a sense of control; a set of questions regarding knowledge and use of various community resources; a set of questions regarding health practices and nutrition. The same questionnaire was used in T3 as in T1 with the exception of the deletion of the nutrition section in T3. T1 data showed no significant differences between any sub-groups and it was decided that this portion of the questionnaire added unnecessarily to the length of the interview.

The interview as finally developed took approximately one hour.

3.3 Sample selection

Between September 11th and November 10, 1972, CCR staff conducted 354 Time 1 interviews at the seven selected sites.

Of the 354 interviews, 67 were conducted with mothers new to the PCC program: those admitted but not yet participating at the time of the interview, or participating for not more than one month. The remaining 287 interviewees were ongoing members who had been participants for six months or more. The gap between new and ongoing members was intentional: through deletion of this "middle range" it might be expected that differences in impact would be cast into sharper focus.

Prior to on-site visits, CCR requested from each of the seven participating Centers a complete listing of ongoing members, and of those accepted for membership within the past month. For each ongoing member, two pieces of information were requested: date of enrollment and a rating of involvement based on a three-point scale. Based upon a discussion with the staff most familiar with each parent, the Directors were asked to assign a rating of (3) to parents who participated frequently and actively, a (1) to parents whose attendance at PCC was sporadic and passive, and a (2) to those parents who fit somewhere in between these end points.

The basic sampling plan called for subdividing each list into seven parts as follows. Among ongoing members, each of the three levels of involvement was divided into two longevity levels (6 to 18 months, and more than 18 months) thus accounting for six groups. The seventh group consisted of new members. Consecutive numbers were assigned to all names within each group. A random numbers table was then used to select individual Ss from each group seven from each involvement group at the low and medium level and eight from each high involvement group. Ten new parents were chosen in the same manner.

Thus, the prepared ideal sampling design would identify

54 *S*s for each PCC as shown in Table II-1 below.

Table II-1. Original sampling plan at each PCC.

LENGTH OF MEMBERSHIP	INVOLVEMENT		
	1	2	3
New members (10)	*	*	*
6-18 months	7	7	8
18 mos - 4 yrs	7	7	8

N=54

* By definition, "new" members could not be rated along this dimension.

The initial target of ten new parents per Center was a pragmatic response to the estimates of PCC Directors as to what new enrollment rates would be during the autumn when most PCCs enroll the greatest number of new participants.

The sampling plan, as originally designed and outlined above, was altered due to field conditions. Length of membership as defined, with a splitting point at 18 months, does not, in fact, divide enrollment lists evenly across all Centers. At one urban PCC, most parents had been in program for more than two years. At another urban Center, many leave after completing one year of program. At Centers where length of membership was heavily skewed toward either end of the continuum, the absolute pre-defined break point of 18 months was discarded and a de facto median point adopted -- that point above and below where half the cases fell.

Involvement ratings requiring subjective judgements also posed a problem. Identical criteria of involvement were not used by any two PCCs. At some PCCs where an hour per week is the average time spent, a person could spend an hour per week in program and be considered highly involved. At other PCCs, such a rating might require attendance two or three days per week. More important from the viewpoint of design, there was a strong relationship between degree of involvement and length of membership: it seemed that those participants who are interested and committed tend to stay in program longer. Long-time low-involved members were in very short supply. In general, more members were rated as being highly involved than medium or low involved.

Sample selection procedures discussed above could be achieved for only two of the seven sample Centers. In the others, selection was based on time of membership and on involvement separately. That is, while approximately half of the ongoing members were long-term and half short, and while approximately one-third were at each involvement level, the distribution within groups, by individual cells (long-term highly involved, short-term medium involved, etc.), was very uneven.

Additional sampling problems were experienced on location. When the names of preselected families were communicated to each PCC, it was hoped that interviewing schedules could be established before the arrival of CCR interviewers. At two Centers, this was not done because of the late arrival or non-arrival of the participant list. Most often, the first interviews were with long-time highly involved members. These were people well known to the staffs and usually friendly with them; therefore they tended to be scheduled for interviews first. Quotas for these cells were soon filled, sometimes within two days of the arrival of the interviewers. Cooperation was often more difficult to obtain from other classes of participants. Schedules had to be rearranged to include time-consuming and interference-filled home visits to those who changed their minds, or who were unable to come to the Center to speak with the interviewers. There was also a number of cases where the selected respondent was unavailable, e.g., a death in the family, travel out of town, hospitalization.

In cases where the participant list was sufficiently large, alternate subjects were preselected to substitute for primary Ss who turned out to be unavailable for interview. Frequently, both the primary and alternate lists were exhausted before the design could be completed. In such situations, interviewers adopted a "universe" approach and interviewed whomever was available in order to ensure adequate sample size.

At three Centers where this "universe" approach method became necessary, interviewers consulted staff members so as to readjust involvement ratings. Names of interviewees were shown to the staff, who reranked Ss on an ordinal continuum from highest to lowest. Involvement level assignments were than made approximately by thirds. While not as methodologically sound as adherence to some absolute standard of involvement, this approach should reflect differences between the high and low levels if such differences do, in fact, exist.

T2 visits were conducted two months after the T1 data collection. Interviews were conducted with all of the new parents and with 10 ongoing parents in order to see if there was any short-range impact right after joining the program. Data analysis showed no significant differences between T1 and T2 and the conclusion reached was that whatever impact there might be was too slight to be visible. Because of the absence of any differences, all data presented in this report are based on T1 and T3 data collection interviews.

T3 data collection was in the period between May 14th and June 25, 1973. All parents remaining with the program until at least March, 1973 were interviewed. A staff member was asked to assign new involvement ratings to all parents and to assign involvement ratings to the sample of parents who had been new at T1.

3.4 Data analysis

3.4.1 Length of membership

Two separate data runs were performed in order to determine the best manner of treating the longevity variable. First, data were broken according to absolute longevity, expressed as exact months of membership. As has already been discussed, this meant that individual PCCs were overrepresented at certain levels and underrepresented at others.

Second, data were run on the basis of a division of Ss according to relative longevity within each Center. As a result, the actual number of months of membership was intermixed at each relative level. For example, the lowest half, determined for each PCC separately, involved those who had been members for up to 13 months at one PCC, nine months at another, and 19 months at a third. Since on-site sampling had not, in every case, adhered strictly to the preplanned longevity breaks, data analyses could proceed in either manner.

While the use of relative breaks produced a few more significant differences among subgroups than did absolute breaks, the distinction was not sufficiently great to warrant such an approach. Particularly as the research is intended to provide a picture of the overall PCC program across all Centers, it appeared relatively more desirable to use the absolute approach. For this reason, absolute breaks were chosen. In all of the T1 analyses presented, short-term members are those who have been with PCC for 6-20 months, and long-term members are those who have been with PCC for over 20 months. In T3 analyses, new members have been in PCC for at least 8 months; short-term members have been with PCC for 14-26 months; long-term members have been in program for more than 26 months.

In terms of longevity, T1 comparisons were made between new, short-term, and long-term families. These findings are presented in the Interim Report. In T3 comparisons were made between T1 and T3 data within each longevity category. Additional analyses were made among the 3 longevity groups, mirroring the T1 analyses.

These analyses can be summarized as follows:

T1

- New family data vs short-term family data
- New family data vs long-term family data
- Short-term family data vs long-term family data

T3

Within group comparisons

- New families at T1 vs new families at T3
- Short-term families at T1 vs short-term families at T3
- Long-term families at T1 vs short-term families at T3

Across group comparisons

- New family data vs short-term family data
- New family data vs long-term family data
- Short-term family data vs long-term family data

The discussion of findings in this report focuses primarily on T1 vs T3 differences. This is because T1 vs T3 comparisons are at the very core of this evaluation. Differences between longevity groups are discussed only in relation to significant findings. In other words, if there is no change in new members from T1 to T3, it really does not matter whether or not the new members are the same or different from another longevity group.

3.4.2 Involvement

A first question which emerged at the time of analysis was whether the involvement ratings should be divided into three levels (as originally planned) or into two, and whether or not the subjective ratings should be combined in some way with more objective measures of participation.

Separate data runs compared two-way and three-way breaks of involvement among ongoing members. New members were not given involvement ratings and were omitted from computations. The two-way break pooled those rated low and medium in involvement versus those rated high and proved to be the more fruitfull approach in terms of the number of statistically significant comparison results. Use of the two-way break had greater face validity as well: PCC staffs tended to feel secure in rating the highest and lowest people, but relatively insecure in the middle range. Since there were more ratings of "high involvement" than in either of the two categories, the two-way break also resulted in fairly numerically equal S groups.

Inspection of the data revealed that there were several PCCs at which most members who were rated as highly involved spent no more than one hour per week in contact with PCC. The inclusion of such respondents in the high involvement group might artificially minimize differences between groups during group comparisons: one hour a week might produce less impact than eight hours a week and so the "highly involved" group would be confounded with respondents who were perhaps not so involved in the absolute sense. As a means to investigating this possibility, comparisons were made among three subgroups in terms of all relevant data. One group was comprised of all parents who were also PCC paraprofessional staff members. These were nearly always rated as highly involved and clearly spend a great number of hours at PCC. Early subjective reports on PCC impact often suggested that the effects of PCC were greatest on those parents who were hired as PCC staff. The second group consisted of non-staff who reported spending more than eight hours per week in PCC activities. The third group consisted of parents who were rated as low involved, and who spent less than one hour per week in PCC activities.

These analyses showed no systematic differences among the groups, i.e., that regrouping Ss according to staff ratings and number of hours did not produce more significant differences than did use of the staff ratings alone. Thus, in all the data presented in this report, involvement is defined solely in terms of ratings done by the PCC staff.

At T3, as already mentioned, PCC staff were asked to do new involvement ratings on the families. Inspection of the T1 and T3 involvement ratings on each individual show a high proportion of change. The involvement status of 35% of the parents changed between T1 and T3. Of these, 70% moved from a rating of low to high involvement and 30% moved from a rating of high to low involvement.

Since involvement ratings for individuals changed from T1 to T3, comparisons along the dimension of involvement are made between high and low involved respondents at T3. In otherwords, comparisons between low-involved individuals at T1 vs T3 or between high-involved idividuals at T1 vs T3 could not be made since over half of the individuals in each group were not the same in T1 as in T3. Thus, involvement data are treated as data from a two occasion cohort sampling rather than as data from a design in which pre and post comparisons are possible.

Involvement data are not presented in Tables and are discussed only when there are significant differences. Differences between high and low respondents which are significant at T1 and are also significant at T3 will be highlighted in the discussion.

3.4.3 Urban vs. rural

In the course of running F-tests on the significance of the Likert data in T1 (the only section for which such a parametric technique was used), it was found that the locale variable was significant much more often than was either length of membership or involvement level. Consequently, chi-squares for all appropriate data were run in terms of the urban/rural variable as well. Chi-square was significant at or beyond the .05 level for 73% of the items. Since these results suggest that two different populations are being sampled, all data in this report are presented separately for the four urban and three rural centers.

3.4.4 Sample attrition

At Tl, 354 interviews were conducted. Eight months later, only 210 Ss were available for reinterview. Distribution of the original sample and the attenuated sample along longevity are presented in Table 1.

Table II-1. Distribution of Tl and T3 sample along longevity.

	LONGEVITY							
		Tl			T3			
	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
URBAN	214 (60)	37 (55)	94 (64)	83 (60)	135 (64)	26 (65)	58 (67)	51 (61)
RURAL	140 (40)	30 (45)	54 (36)	56 (40)	75 (36)	14 (35)	28 (33)	33 (39)
TOTAL	354	67	148	139	210	40	86	84

Approximately fifty-nine percent of the original sample was available for reinterview. Sixty percent of the new families, 58% of the short-term members, and 60% of the long-term members were available for reinterview. Thus, there is no systematic bias in the attenuated sample in terms of longevity.

Sixty-three percent of the urban sample and fifty-four percent of the rural sample was available for reinterview. The higher rate of rural dropouts is a function of the fact that during the 8 month time lapse between T1 and T3 as described in Chapter I, one rural Center changed its entire program and thus lost the majority of its membership in the process, and a second rural Center closed two of its four sites and also lost a considerable number of members.

Reasons that Ss were unavailable for reinterview are presented in Table II-2.

Table II-2. Reasons underlying parents unavailability for T3 interviews.

TERMINATED	MOVED	UNAVAILABLE	JOBS/ SCHOOL
96	23	19	6

The great majority of the 144 parents unavailable for T3 interviews, terminated from program. Terminations include those parents who had to dropout because a Center changed its program or closed down several sites, program graduates, and those who were dropped for non-participation. Parents in the unavailable category include several in the hospital and several who were out of town at the time of T3 interviews.

In order to determine whether the attenuated T3 sample was in any way biased, chi-square analyses were performed comparing all T1 data on those who were available and those who were unavailable for T3 interviews. These analyses show that there are no significant differences between the original and attenuated sample along impact dimensions.

All T1 data presented in the following chapters are based only on data from Ss available for both T1 and T3 interviews. For purposes of clarity, T3 interviews are from this point on referred to as T2.

CHAPTER III

DEMOGRAPHIC AND BACKGROUND DATA

1.0 Demographic and background data

This chapter will serve as an introduction to the sample population in order to provide the reader with a picture of the sample.

1.1 Who was interviewed

In Time 1, 354 parents were interviewed. In Time 2, 210 of the original 354 parents were reinterviewed. Following, is a breakdown of the sample according to length of time in the program.

Table III-1. Distribution of subjects along the longevity variable.

	LONGEVITY			
	TOTAL	NEW	SHORT	LONG
Urban	135	26	58	51
Rural	75	14	28	33
Total	210	40	86	84

All tables will present the number of respondents (N) in each category and the percentage of the category total that each N represents. The sample is broken down into two subsamples: urban and rural. Each subsample is further subdivided by the major study variable: longevity. As discussed in Chapter II, the three subdivisions along the longevity variable are: new, short, and long. The length of time that participants had been in program at the time of T1 and T2 data collection is presented below.

	TIME 1	TIME 2
New	<1 month	8 months
Short	6-20 months	14-26 months
Long	> 20 months	> 26 months

1.2 About the respondents

1.2.1 Sex

Table III-2. Sex of respondents.

	URBAN-RURAL TOTALS				URBAN				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Male	8 (4)	- -	1 (1)	7 (8)	8 (6)	- -	1 (2)	7 (14)	- -	- -	- -	- -
Female	202 (96)	40 (100)	85 (99)	77 (92)	127 (94)	26 (100)	57 (98)	44 (86)	75 (100)	14 (100)	28 (100)	33 (100)
Base	210	40	86	84	135	26	58	51	75	14	28	33

CCR interviewed the person who had primary responsibility for child care in each sample family. Eight males are included in the sample, all are from urban areas and all except one have had long-term involvement with PCC. Ninety-six percent of the sample is female.

1.2.2 Age

Table III-3. Age of respondents.

	URBAN-RURAL TOTALS				URBAN				RURAL*			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Under 21	33 (16)	11 (28)	20 (23)	2 (2)	28 (21)	8 (31)	18 (31)	2 (4)	5 (7)	3 (21)	2 (7)	- -
21 - 30	116 (55)	22 (55)	51 (59)	43 (51)	72 (53)	16 (61)	30 (52)	26 (51)	44 (59)	6 (43)	21 (75)	17 (52)
31 - 40	49 (23)	6 (15)	10 (12)	33 (39)	28 (21)	2 (8)	6 (10)	20 (39)	21 (28)	4 (28)	4 (14)	13 (39)
41 - 50	10 (5)	1 (2)	4 (5)	5 (6)	5 (4)	- -	3 (5)	2 (4)	5 (7)	1 (7)	1 (4)	3 (9)
Over 50	2 (1)	- -	1 (1)	1 (1)	2 (2)	- -	1 (2)	1 (2)	- -	- -	- -	- -
Base	210	40	86	84	135	26	58	51	75	14	28	33

*Chi-square significant at .05 level.

The majority of the respondents are in the 21 to 30 year age group. Fifty-three percent of the urban and fifty-nine percent of the rural sample are in this category.

Rural respondents tend to be slightly older than are urban respondents. Thirty-five percent of the rural subsample is between the ages of 30 and 50 while only twenty-seven percent of the urban subsample is this old. Conversely, there are more urban respondents under 21 years of age: 21% fall in this category as opposed to 7% of the rural subsample.

Long-time respondents are considerably older than the new or short-term groups. In the urban subsample, 45% of the long-time members are over 30 years of age while only 8% of the new and 17% of the short-time members are over 30. In the rural subsample this age difference between long-term members and others is significant. Forty-eight percent of the long-time members are over 30 while only 18% of the short-time members are over 30 years old.

Several urban PCCs have stressed their interest in enrolling very young mothers in their programs. They feel that they can better influence and teach those who are expecting their first child or those who have had only one or two children. Thirty-one percent of the urban new parents are under 21; only 21% of the rural new parents are in this age group.

1.2.3 Ethnicity

Table III-4. Ethnic grouping of respondents.

	URBAN-RURAL TOTALS				URBAN				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Black	103 (49)	20 (50)	52 (60)	31 (37)	103 (76)	20 (77)	52 (90)	31 (61)	- -	- -	- -	- -
Puerto Rican	4 (2)	- -	1 (1)	3 (4)	4 (3)	- -	1 (2)	3 (6)	- -	- -	- -	- -
Mexican-American	27 (13)	5 (12)	6 (7)	16 (19)	19 (14)	4 (15)	2 (3)	13 (25)	8 (11)	1 (7)	4 (14)	3 (9)
Other Caucasian	68 (32)	13 (32)	24 (28)	31 (37)	5 (4)	1 (4)	1 (2)	3 (6)	63 (84)	12 (86)	23 (82)	28 (85)
Oriental	4 (2)	1 (3)	2 (2)	1 (1)	4 (3)	1 (4)	2 (3)	1 (2)	- -	- -	- -	- -
American Indian	4 (2)	1 (3)	1 (1)	2 (2)	- -	- -	- -	- -	4 (5)	1 (7)	1 (4)	2 (6)
Base	210	40	86	84	135	26	58	51	75	14	28	33

Blacks account for half (49%) of the total sample; all are in urban areas making up three-quarters of that subsample. The next largest group is "other Caucasian" amounting to 32% of the total sample but constituting approximately four-fifths (84%) of the rural subsample.

Besides "other Caucasians" there are only two other ethnic groups in the rural areas. Among the urban subsample, however, all ethnic groups except American Indians are represented.

Blacks and "other Caucasians" comprise an equal proportion of long-term members. Both groups equal 37%.

The third largest ethnic group in this study, Mexican-Americans, are over-represented in the long-time group of respondents. This discrepancy is due to sampling error. The Mexican-Americans all come from one urban Center whose membership tends to be skewed in the direction of longevity.

1.2.4 Education

Table III-5. Education of respondents.

	URBAN-RURAL TOTALS				URBAN				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
6th grade or less	20 (10)	2 (5)	5 (6)	13 (15)	14 (10)	1 (4)	3 (5)	10 (20)	6 (8)	1 (7)	2 (7)	3 (9)
7 - 9	37 (18)	5 (12)	15 (17)	17 (20)	17 (12)	2 (8)	10 (17)	5 (10)	20 (27)	3 (21)	5 (18)	12 (36)
10 - 11	67 (32)	13 (33)	27 (31)	27 (32)	46 (34)	6 (23)	20 (34)	20 (39)	21 (28)	7 (50)	7 (25)	7 (21)
Completed High School	63 (30)	14 (35)	27 (31)	22 (26)	39 (29)	11 (42)	16 (28)	12 (24)	24 (32)	3 (21)	11 (39)	10 (30)
Some College	20 (10)	5 (12)	12 (14)	3 (4)	16 (12)	5 (19)	9 (16)	2 (4)	4 (5)	- -	3 (11)	1 (3)
College graduate	3 (1)	1 (3)	- -	2 (2)	3 (2)	1 (4)	- -	2 (4)	- -	- -	- -	- -
Base	210	40	86	84	135	26	58	51	75	14	28	33

In terms of level of education, the urban respondents are better educated than are their rural counterparts. Seventy-seven percent of the urban respondents have had over ten years of school; only 65% of the rural parents have had this much education. The urban respondents are more heavily represented among those who have had some college education and among college graduates (14% as compared to 5% rural).

Among both groups, the new members tend to be more educated than are long-time members; a greater difference, although non-significant, exists in the rural subsample. Among new members, 88% of the urban and 71% of the rural respondents have had ten or more years of education. For long-time members, these figures are 71% and 54%, respectively.

1.3 Respondents' families

1.3.1 The children: total number per family

Table III-6. Total number of children per family.

	URBAN-RURAL TOTALS				URBAN***				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
One	36 (17)	16 (40)	19 (22)	1 (1)	26 (19)	11 (42)	14 (24)	1 (2)	10 (13)	5 (36)	5 (18)	- -
Two	47 (22)	6 (15)	26 (30)	15 (18)	34 (25)	6 (23)	18 (31)	10 (20)	13 (17)	- -	8 (28)	5 (15)
Three	39 (19)	8 (20)	13 (15)	18 (21)	27 (20)	4 (15)	11 (20)	12 (24)	12 (16)	4 (29)	2 (7)	6 (18)
Four	26 (12)	2 (5)	10 (12)	14 (17)	13 (10)	- -	5 (9)	8 (16)	13 (17)	2 (14)	5 (18)	6 (18)
Five	19 (9)	4 (10)	6 (7)	9 (11)	8 (6)	2 (8)	2 (3)	4 (8)	11 (15)	2 (14)	4 (14)	5 (15)
Six	15 (7)	2 (5)	3 (3)	10 (12)	11 (8)	2 (8)	2 (3)	7 (14)	4 (5)	- -	1 (4)	3 (9)
Seven	14 (7)	2 (5)	4 (5)	8 (10)	6 (4)	1 (4)	3 (5)	2 (4)	8 (11)	1 (7)	1 (4)	6 (18)
Eight	5 (2)	- -	2 (2)	3 (4)	4 (3)	- -	1 (2)	3 (6)	1 (1)	- -	1 (4)	- -
Nine or more	9 (4)	- -	3 (3)	6 (7)	6 (4)	- -	2 (3)	4 (8)	3 (4)	- -	1 (4)	2 (6)
Base	210	40	86	84	135	26	58	51	75	14	28	33
Mean no. of children/family	3.60	2.65	3.13	4.52	3.41	2.46	2.97	4.41	3.92	3.00	3.46	4.70

***Chi-square significant at .001 level

Rural families tend to have more children than do urban families. The mean number of children among rural families is 3.92 as opposed to 3.41 children per urban family. Over half (53%) of the rural respondents have four or more children while this is the case among only 35% of the urban respondents.

Long-time respondents, both urban and rural, have considerably more children than do the other two groups. These differences are significant for the urban sample. This is as expected since long-time members, being older, have had more time in which to bear children. New members in both groups have the least number of children. The mean number of children for urban new respondents is 2.46 and 4.41 for long-time members; for rural respondents the figures are 3.00 and 4.75 respectively.

1.3.2 Intact families

Table III-7. Number of respondents with spouse living at home.

	URBAN-RURAL TOTALS				URBAN*				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Spouse at home	102 (49)	15 (38)	36 (42)	51 (61)	53 (39)	8 (31)	18 (31)	27 (53)	49 (65)	7 (50)	18 (64)	24 (73)
No spouse at home	108 (51)	25 (62)	50 (58)	33 (39)	82 (61)	18 (69)	40 (69)	24 (47)	26 (35)	7 (50)	10 (36)	9 (27)
Base	210	40	86	84	135	26	58	51	75	14	28	33

*Chi-square significant at .05 level

Looking at the total sample, approximately one-half of the respondents have spouses living at home. However 61% of the urban respondents have no spouse at home, while only 35% of the rural subsample are in this category.

Fewer urban new (31%) than long-time (53%) respondents have spouses living at home. These differences are statistically significant. One possible explanation is that long-term parents have more confidence in PCC and therefore are less apt to cover up the fact that they have a husband in the home, which affects eligibility for welfare benefits. New urban parents, having less trust in the PCC, might not be willing to reveal this information to the interviewer. Another factor which might contribute to the finding that there are more intact families among long-time than among new parents may be that long-time parents, being older, are more stable in their marital relationships.

1.4 Involvement in PCC

1.4.1 Respondents' involvement - time spent at PCC

Table III-8a. Average time spent at PCC each week - urban.*

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
0-1 hour per week	20 (18)	- -	7 (12)	13 (25)	37 (27)	9 (35)	17 (29)	11 (22)
1-2 hours per week	19 (17)	- -	12 (21)	7 (14)	12 (9)	3 (12)	6 (10)	3 (6)
2-4 hours per week	22 (20)	- -	16 (28)	6 (12)	31 (23)	8 (31)	8 (14)	15 (29)
4-8 hours per week	16 (15)	- -	6 (10)	10 (20)	15 (11)	2 (8)	6 (10)	7 (14)
8+ hours per week	32 (29)	- -	17 (29)	15 (29)	40 (30)	4 (15)	21 (36)	15 (29)
Base	109	-	58	51	135	26	58	51

*New families not included in T1.

Table III-8b. Average time spent at PCC each week - rural.*

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
0-1 hour per week	7 (11)	- -	6 (21)	1 (3)	19 (25)	6 (43)	6 (21)	7 (21)
1-2 hours per week	6 (10)	- -	3 (11)	3 (9)	13 (17)	3 (21)	6 (21)	4 (12)
2-4 hours per week	12 (20)	- -	4 (14)	8 (24)	10 (13)	1 (7)	4 (14)	5 (15)
4-8 hours per week	19 (31)	- -	9 (32)	10 (30)	6 (8)	- -	2 (7)	4 (12)
8+ hours per week	17 (28)	- -	6 (21)	11 (33)	27 (36)	4 (28)	10 (36)	13 (39)
Base	61	-	28	33	75	14	28	33

*New families not included in T1.

New members were asked how much time they spent at PCC only during T2 interviews. By this time, they had been in program for at least eight months. It would be expected that new members with a new interest in PCC would spend a great deal of time at PCC. However, 47% of the urban and 64% of the rural new members spend less than two hours each week at PCC.

Urban short-time respondents are the only group to have somewhat increased the amount of time they spend at PCC from T1 to T2. Thirty-nine percent of this group spent four or more hours at PCC at T1; at T2 this number increased to 46%.

The greatest differences are exhibited by the rural subsample. While over one-half (53%) of the rural short-time members spent over four hours at PCC at T1, only 43% remain in this category at T2. Among rural long-time members, the proportion of members spending over four hours at PCC has decreased from 63% at T1 to 51% at T2. More short-time and long-time members are spending from one to two hours at PCC at T2 than at T1.

The most likely explanation for this decrease in time spent at rural PCCs is the changes in two of the three rural programs that have occurred between T1 and T2. As described in Chapter I, there has been a shift in the direction of less emphasis on in-Center programs and more emphasis on outreach. Some respondents who, at T1 came into the Center, are only seen in their homes at T2.

1.4.2 Time spent per week on PCC activities at home.

Table III-9a. Average time spent at home on PCC activities - urban.[1]

	TIME 1				TIME 2			
RESPONSES	TOTAL**	NEW	SHORT	LONG*	TOTAL**	NEW	SHORT	LONG*
0-1 hour	36 (33)	- -	14 (24)	22 (43)	40 (30)	11 (42)	13 (22)	16 (31)
1 - 2 hours	20 (18)	- -	11 (19)	9 (18)	16 (12)	5 (19)	7 (12)	4 (8)
2 - 4 hours	17 (16)	- -	8 (14)	9 (18)	19 (14)	5 (19)	6 (10)	8 (16)
4 - 8 hours	15 (14)	- -	10 (17)	5 (10)	20 (15)	1 (4)	9 (16)	10 (20)
8+ hours	21 (19)	- -	15 (26)	6 (12)	40 (30)	4 (15)	23 (40)	13 (25)
Base	109	-	58	51	135	26	58	51

[1] New families not included in T1.

*Chi-square significant at .05 level.
**Chi-square significant at .01 level.

Table III-9b. Average time spent at home on PCC activiities - rural.[1]

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG*	TOTAL	NEW	SHORT	LONG*
0-1 hour	13 (21)	- -	8 (29)	5 (15)	7 (9)	1 (7)	6 (21)	- -
1 - 2 hours	14 (23)	- -	2 (7)	12 (36)	11 (15)	1 (7)	3 (11)	7 (21)
2 - 4 hours	11 (18)	- -	6 (21)	5 (15)	21 (28)	4 (28)	10 (36)	7 (21)
4 - 8 hours	13 (21)	- -	8 (29)	5 (15)	11 (15)	3 (21)	2 (7)	6 (18)
8+ hours	10 (16)	- -	4 (14)	6 (18)	25 (33)	5 (36)	7 (25)	13 (39)
Base	61	-	28	33	75	14	28	33

[1] New families not included in T1.

*Chi-square significant at .05 level.

While respondents report spending less time at the PCC, they are, in general, spending more time at home working with their children on PCC activities. The increase of time spent at home on PCC-related activities by urban respondents over this time period is significant.

The percentage of urban short-time parents spending over four hours per week on PCC activities at home increased from 43% at T1 to 56% at T2. Among urban long-time members, the increase in the proportion of parents reporting that they spend over four hours a week working with their children is significant.

Rural long-time members report the largest increase, also significant, in time spent at home on PCC-related activities. The percentage of these members spending over four hours at home rose from 33% to 57%.

Rural new respondents spend considerably more time at home on PCC-related activities than do urban new respondents. Fifty-seven percent of the former spend over four hours on these activities while only 19% of urban new members spend this much time. Sixty-one percent of the urban new parents spend less than two hours per week at home on PCC-related activities.

Rural respondents, because of lack of transportation and isolation, are at home more than urban respondents. Rural respondents, unlike urban mothers, may not have anyone with whom to leave their children and so they must stay home more of the time. Therefore, they may have more opportunity, in terms of time, to engage in PCC-related activities.

1.4.3 Policy Advisory Council membership

Table III-10a. Number of sample parents belonging to the PAC-urban.

	TIME 1				TIME 2			
RESPONSES	TOTAL*	NEW	SHORT	LONG	TOTAL*	NEW	SHORT	LONG
Council member	24 (18)	1 (4)	13 (22)	10 (20)	41 (30)	8 (31)	16 (28)	17 (33)
Non-council member	111 (82)	25 (96)	45 (78)	41 (80)	94 (70)	18 (69)	42 (72)	34 (67)
Base	135	26	58	51	135	26	58	51

*Chi-square significant at the .05 level.

Table III-10b. Number of sample parents belonging to the PAC - rural.

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Council member	20 (27)	- -	9 (32)	11 (33)	14 (19)	3 (21)	4 (14)	7 (21)
Non-council member	55 (73)	14 (100)	19 (68)	22 (67)	61 (81)	11 (79)	24 (86)	26 (79)
Base	75	14	28	33	75	14	28	33

One-fourth of the parents interviewed as part of this study are members of their respective PACs. Membership increased from 21% at T1 to 26% at T2.

Eleven of the new members have joined the PAC during the course of their first program year; twenty-nine have not. More urban short-time and long-time respondents are members of the PAC at T2 than at T1. On the whole, the number of urban respondents belonging to the PAC increased significantly from T1 to T2. The number of rural short-time and long-time respondents have, however, decreased in membership in PAC. Again, with reorganization and consolidation of rural PCCs, a turnover of membership in the Policy Advisory Councils is to be expected.

1.5 Employment

1.5.1 Employment status - mothers

Table III-11a. Mothers' employment status - urban.

	BEFORE JOINING PCC				AFTER JOINING PCC*			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Employed full-time	17 (13)	2 (8)	7 (12)	8 (16)	19 (14)	2 (8)	6 (10)	11 (22)
Employed part-time	8 (6)	1 (4)	3 (5)	4 (8)	12 (9)	1 (4)	5 (9)	6 (12)
Not employed	110 (81)	23 (88)	48 (83)	39 (76)	104 (77)	23 (88)	47 (81)	34 (67)
Base	135	26	58	51	135	26	58	51

*Chi-square significant at .05 level.

Table III-11b. Mothers' employment status - rural.

	BEFORE JOINING PCC				AFTER JOINING PCC			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Employed full-time	6 (8)	1 (7)	3 (11)	2 (6)	16 (21)	1 (7)	6 (21)	9 (27)
Employed part-time	13 (17)	1 (7)	6 (21)	6 (18)	7 (9)	1 (7)	3 (11)	3 (9)
Not employed	56 (75)	12 (86)	19 (68)	25 (76)	52 (69)	12 (86)	19 (68)	21 (64)
Base	75	14	28	33	75	14	28	33

Unemployment decreased very slightly (from 79% to 74%) following enrollment in PCC. The proportion of parents gaining some form of employment after joining PCC is approximately the same for urban and rural respondents. Among urban respondents, unemployment decreased from 81% to 77% while it decreased from 75% to 69% for rural members. Employment is greater among rural than among urban respondents. Higher employment in rural areas is a function of seasonal farm employment and of the fact that the rural PCCs in this sample employ a relatively large number of parents. Urban PCCs do not employ as many parents, in fact, one urban PCC does not employ PCC mothers as a matter of policy.

New members in both groups have the smallest percentage of employment. At T1 there is a statistically significant relationship, among urban respondents, between the length of time a respondent has been a PCC member and employment status. Long-time members comprise the largest percentage of full-time employed respondents.

1.5.2 Employment status - fathers

Table III-12a. Fathers' employment status - urban.

	BEFORE JOINING PCC				AFTER JOINING PCC			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Employed full-time	36 (60)	3 (38)	14 (67)	19 (61)	39 (65)	3 (38)	16 (76)	20 (65)
Employed part-time	7 (12)	1 (12)	3 (14)	3 (10)	5 (8)	1 (13)	1 (5)	3 (10)
Not employed	17 (28)	4 (50)	4 (19)	9 (29)	16 (27)	4 (50)	4 (19)	8 (26)
Base: no. of spouses reporting work status	60	8	21	31	60	8	21	31

Table III-12b. Fathers' employment status - rural.

	BEFORE JOINING PCC				AFTER JOINING PCC			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Employed full-time	34 (69)	4 (57)	11 (61)	19 (79)	31 (63)	1 (14)	11 (61)	19 (79)
Employed part-time	11 (22)	2 (29)	5 (28)	4 (16)	9 (18)	2 (29)	4 (22)	3 (13)
Not employed	4 (8)	1 (14)	2 (11)	1 (4)	9 (18)	4 (57)	3 (17)	2 (8)
Base: no. of sponses reporting work status	49	7	18	24	49	7	18	24

The number of fathers reporting work status is larger than the number of fathers living at home. This is due to the fact that fathers may, in fact, make economic contributions to the family but the parents may be separated, with the father living elsewhere.

Unemployment is higher among urban than among rural fathers. This is a result of the availability of seasonal employment in rural areas. Also as a result of such seasonal employment, part-time employment is higher among rural than among urban fathers.

Over time, there is very little change in employment status. New fathers account for the highest percentage of unemployed in both the urban and rural subsamples.

1.5.3 Changes in employment status

Table III-13. Changes in employment status at T2.[1]

	URBAN-RURAL TOTALS				URBAN				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
EMPLOYMENT STATUS CHANGE	73 (35)	14 (35)	26 (30)	33 (39)	42 (31)	7 (27)	15 (26)	20 (39)	31 (41)	7 (50)	11 (39)	13 (39)
NO EMPLOYMENT CHANGE	137 (65)	26 (65)	60 (70)	51 (61)	93 (69)	19 (73)	43 (74)	31 (61)	44 (59)	7 (50)	17 (61)	20 (61)
Husband now employed full-time	14 (19)	4 (28)	2 (8)	8 (24)	6 (14)	1 (14)	1 (7)	4 (20)	8 (26)	3 (43)	1 (9)	4 (31)
Husband now employed part-time	3 (4)	- -	1 (4)	2 (6)	1 (2)	- -	- -	1 (5)	2 (6)	- -	1 (9)	1 (8)
Husband now unemployed	6 (8)	1 (7)	2 (8)	3 (9)	4 (10)	1 (14)	- -	3 (15)	2 (6)	- -	2 (18)	- -
Wife now employed full-time	34 (46)	6 (43)	13 (50)	15 (45)	19 (45)	3 (43)	8 (53)	8 (40)	15 (48)	3 (43)	5 (45)	7 (54)
Wife now employed part-time	10 (14)	1 (7)	5 (19)	4 (12)	7 (17)	- -	4 (27)	3 (15)	3 (10)	1 (14)	1 (9)	1 (8)
Wife now unemployed	6 (8)	2 (14)	3 (12)	1 (3)	5 (12)	2 (29)	2 (13)	1 (5)	1 (3)	- -	1 (9)	- -
Base	210	40	86	84	135	26	58	51	75	14	28	33

[1] percentages for specific employment changes based on respondents reporting an employment status change.

Of those experiencing a change in employment status, the greatest change is in the direction of more wives becoming employed on a full-time basis. Nineteen urban and fifteen rural respondents report having gotten full-time jobs.

1.5.4 PCC's role in aiding parents' employment

Table III-14. PCC's role in aiding parents' employment.[1]

	URBAN-RURAL TOTALS				URBAN				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
PCC helped	28 (46)	3 (27)	10 (48)	15 (52)	15 (45)	1 (25)	6 (46)	8 (50)	13 (46)	2 (29)	4 (50)	7 (54)
No PCC involvement	33 (54)	8 (73)	11 (52)	14 (48)	18 (55)	3 (75)	7 (54)	8 (50)	15 (54)	5 (71)	4 (50)	6 (46)
Base	61	11	21	29	33	4	13	16	28	7	8	13

[1] Asked only of those respondents reporting work status change that resulted in employment at T2.

Of the respondents who report having gained employment at T2, approximately half received PCC aid (46%) and half did not (54%). There are variations, however, according to respondent group.

Very few of the new respondents report receiving PCC aid in gaining employment. Rural long-time respondents received the most PCC help. This is, again, most likely a result of employment by the PCC, itself. The total number (28) of parents who have become employed as a result of PCC involvement is very small, which suggests that despite some compelling case history materials on parents who have joined the work force, assistance with unemployment problems is not a major PCC thrust.

1.6 Welfare

Table III-15a. Number of participants on welfare - urban.

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Receiving welfare at time of interview	86 (64)	19 (73)	39 (67)	28 (55)	84 (62)	18 (69)	39 (67)	27 (53)
Not receiving welfare	49 (36)	7 (27)	19 (33)	23 (45)	51 (38)	8 (31)	19 (33)	24 (47)
Base	135	26	58	51	135	26	58	51

Table III-15b. Number of participants on welfare - rural.

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Receiving welfare at time of interview	29 (39)	6 (43)	11 (39)	12 (36)	33 (44)	8 (57)	13 (46)	12 (36)
Not receiving welfare	46 (61)	8 (57)	17 (61)	21 (64)	42 (56)	6 (43)	15 (54)	21 (64)
Base	75	14	28	33	75	14	28	33

Over one-half of all respondents interviewed are receiving welfare. Between T1 and T2, there is virtually no change in the number of persons on welfare. More urban respondents receive welfare benefits than do rural respondents.

Proportionately fewer long-time than new or short-time respondents are on welfare. This is probably a function of the fact that more of these families have husbands living at home.

2.0 SUMMARY

AGE

- Most respondents are between the ages of 21 and 30.
- Rural respondents tend to be older than urban parents.
- New members represent the youngest group.

ETHNICITY

- Blacks account for 49% of the sample.
- Other Caucasians account for 32%.

CHILDREN PER FAMILY

- Rural families tend to be larger than urban families.
- New members, being younger, have fewer children.

INTACT FAMILIES

- The percentage of intact families is almost twice as high for rural as for urban respondents.
- Long-time members have a higher proportion of intact marriages.
- Fewer new members have husbands.

TIME SPENT AT PCC

- Respondents are spending less time at PCC, but more time at home on PCC-related activities when T1 and T2 comparisons are drawn.

PAC MEMBERSHIP

- One-fourth of the parents interviewed are on the PAC.

EMPLOYMENT STATUS

- The majority of PCC mothers are unemployed.
- Employment is higher among long-time members.
- Employment is higher among rural than among urban parents as a function of the availability of seasonal employment in rural areas.
- PCC assistance in obtaining employment effects only a small minority of PCC families.
- Fifty-five percent of the sample is on welfare. There are virtually no changes in welfare status over the course of the program year.

CHAPTER IV

PARENTING

In this chapter all findings pertaining to parenting knowledge and behavior will be presented, including data from the following sources:

- open-ended parenting items in which Ss were asked to present alternative solutions to everyday problem situations.
- open-ended questions dealing with child rearing issues and with likes and dislikes with respect to parenting.
- questions pertaining to the perceived impact that PCC has had on children and on parental parenting skills.
- a series of Likert items that specifically deal with parenting behavior and attitudes.

1.0 Alternative solutions to everyday problems

The emphasis of the research was to avoid judgements about what is "good" and "bad" parenting. It was felt that the most important change in parenting as an impact of PCC might be the awareness that in nearly any situation involving a child, there are always several possible alternatives for action. Awareness of differing options does not imply inconsistency. A mother who is knowledgeable about child development is more likely to think of a variety of reasons as to why the behavior is occurring, and is more likely to be sensitive to both the nuances of context, and the fact that the same behavior at different developmental stages has different meaning, and thus should be handled differently. Repeated use of the same approach, regardless of age or context, implies rigidity, not consistency.

At T1, it was predicted that when a child's problem behavior was presented, long-term PCC mothers would give more sensitive and responsible alternative solutions because they would be aware of the need to take into account the child's developmental age, and they would be aware that any behavior has a great variety of possible underlying meanings. While this prediction was maintained at T2, it was also predicted that an increase in such solutions would be presented by new parents as a result of their participation in the PCC program.

1.1 Stimulus materials

A brief description of each problem situation was given to the respondent with the following set of instructions:

> "There are a lot of common, everyday situations that happen when you're bringing up children. What I'm going to do is to read you several different types of situations, one at a time, and I'd like you to tell me what you would do in each situation -- how you would handle it if you had to. If you see several different ways of handling any one situation, be sure to tell me all of them."

Interviewers were instructed to continue probing until the respondent had exhausted all the solutions within her repertoire. To avoid possible annoyance upon repeated quizzing, interviewers warned the respondents that they would continually be asked what other solutions they could think of until they ran out of ideas. Thus, an active attempt was made to have respondents generate as many solutions as they could. Otherwise, respondents who had many ideas, but who were shy of the interviewing situation might be under-represented. This was of particular concern at T1 among new parents who might not be as used to being interviewed as were ongoing PCC parents.

On a number of occasions, parents told the interviewer that they could not respond to a situation because it never occurred with their children. For example, a mother faced with the situation: "if your baby refuses to go to sleep at night when you put him down -- if he won't stop crying -- what do you do?" might answer by saying, "Oh, I've never had any problems with that." Or, a mother may not have a child old enough to be running around hitting other children. In these cases, respondents were told to make believe that they had the problem, or to imagine what they might do if they did encounter the situation or to suppost that they were approached for advice by another mother who had the problem.

Space was left on the questionnaire for up to five responses and comments for each situation. Very few respondents gave five responses to an item and so these were omitted from tabulation; it was found that a subject would stand out by just giving four answers, as there were relatively few of even these.

Additional measures were included in the T2 interview. Interviewers were instructed to note each time a respondent presented a solution which gave overt recognition either to the age of the child, the emotional needs of the child, or the context of the situation. That is, if a mother were to say something similar to "If the child is too young to understand an explanation, I might try distracting his attention," she would then receive a notation for an age appropriate response. In addition, if the respondent makes note of such things as the child's special need for attention due to a particular situation, the item would be coded to show an understanding that responses differ according to the child's emotional needs and the context of the situation.

1.2 Analyses of data

Item codes were developed at T1 by using a sample drawn from the 354 questionnaires, representing all subgroups: locale (urban/rural), length of membership (new/short/long), and involvement (low/high).

Inspection of the data made it clear that certain kinds of solutions tend to be given as first solutions, while others tend to appear later. For instance, respondents tend not to use physical punishment as a first solution, but the mention of physical punishment becomes more frequent as a third or fourth alternative. For each parenting item, data on the following measures are presented:

- Distribution of the number of solutions generated.
- Distribution of first solutions.
- Distribution of all solutions.
- Distribution of age - appropriate responses (T2 only).
- Distribution of emotional need recognition or context responses (T2 only).

Chi-square analyses were performed where feasible, separately for each subsample (urban and rural) to compare:

- New parents vs. short-time parents vs. long-time parents at T1.
- New parents vs. short-time parents vs. long-time parents at T2.
- New parents at T1 vs. new parents at T2.
- Short-time parents at T1 vs. short-time parents at T2.

- Long-time parents at T1 vs. long-time parents at T2.
- Total subsample at T1 vs. total subsample at T2.
- High involved parents at T1 vs. low involved parents at T1.
- High involved parents at T2 vs. low involved parents at T2.

In many cases, so many codes were generated from the qualitative data that the chi-square analyses become impractical due to the great number of cells, and the resulting small cell Ns. Wherever possible, response categories were collapsed and clustered to increase cell size and permit chi-square analyses. Precautions were taken to ensure that only responses of similar quality were clustered together.

In addition, t-tests were performed in order to measure differences, both within subsamples and over time, in the number of alternative solutions generated. Such tests were performed on involvement as well as longevity data. As few significant differences were produced by the involvement data, these are not presented.

1.3 "Child grabs an unwanted item while mother shops"

The first item was "Suppose that you take your child to the store and he grabs for something he wants and insists on having it. The thing is not anything you intended to buy. What do you do?"

The situation is indeed common. It was intended to evoke the picture of a busy, perhaps harassed mother trying to do an everyday chore. While some mothers responded in relation to a grocery store and others the five and dime, all mothers conveyed the sense that at some time they had experienced the situation. From the solutions generated at T1, six codes were developed for this item and used for both sets of interviews.

- EXPLANATION:

  Reasons why the item is not necessary or desirable, stating ground rules for the child's conduct when shopping.

- DISTRACTION:

  Occupying the child with something already in the shopping cart, taking the child immediately to another part of the store, or simply distracting his attention by talking about something else of interest to the child.

- NEGATIVE REINFORCEMENT WITHOUT PUNISHMENT:

  The item is removed from the child and returned, or the child is removed from the store.

- POSITIVE REINFORCEMENT:

  This code is used for maternal behavior which acts as a reinforcement of the child's negative behavior. In other words, the basic message to the child is "if you grab something, there's something in it for you because you'll get something out of it," e.g., buying a substitute item, promising a toy or privilege later, or agreeing to purchase the actual item, even though the purchase is unintended.

° THREATENING PUNISHMENT:

Verbalizing punishments which follow if the item is not relinquished.

° PHYSICAL PUNISHMENT:

Any form of slapping, hitting, spanking.

1.3.1 The number of solutions

Table IV-1a. "The child grabs something in store": distribution of the number of solutions - urban.

	TIME 1				TIME 2			
RESPONSES	TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response N	30	10	9	11	21	4	5	12
%	(22)	(38)	(16)	(22)	(16)	(15)	(9)	(24)
Two responses N	58	11	28	19	74	15	32	27
%	(43)	(42)	(48)	(37)	(55)	(58)	(55)	(53)
Three responses N	41	5	18	18	32	6	17	9
%	(30)	(19)	(31)	(35)	(24)	(23)	(29)	(18)
Four responses N	6	-	3	3	8	1	4	3
%	(4)	-	(5)	(6)	(6)	(4)	(7)	(6)
Mean	2.17	1.81	2.26	2.25	2.20	2.15	2.34	2.06
S.D.	.82	.73	.78	.86	.77	.72	.73	.80
Base: number of respondents	135	26	58	51	135	26	58	51

t1-2 = -2.47; P=<.01
t1-3 = -2.21; P=<.05
t1-4 = -1.84; P=<.05

Table IV-1b. "The child grabs something in store": distribution of the number of solutions - rural.

	TIME 1				TIME 2			
RESPONSES	TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response N	21	4	6	11	11	2	4	5
%	(28)	(29)	(21)	(33)	(15)	(14)	(14)	(15)
Two responses N	32	7	13	12	47	8	20	19
%	(43)	(50)	(46)	(36)	(63)	(57)	(71)	(58)
Three responses N	19	2	8	9	16	4	3	9
%	(25)	(14)	(29)	(27)	(23)	(29)	(11)	(27)
Four responses N	3	1	1	1	-	-	1	-
%	(4)	(7)	(4)	(3)	-	-	(4)	-
Mean	2.05	2.00	2.14	2.00	2.08	2.14	2.04	2.12
S.D.	.83	.84	.79	.85	.60	.64	.62	.64
Base: number of respondents	75	14	28	33	75	14	28	33

Among both urban and rural respondents, there has been a slight increase in the number of alternative solutions offered in response to this item. The most striking increase occurred among new members; at T1 the overwhelming majority of new parents gave between one and two solutions, whereas at T2, over three-quarters of this subsample offered two or three alternatives. On the whole, the differences between subgroups diminished in T2 in terms of the number of solutions generated.

An inspection of the longevity breakdowns in the data show that the increase in responses generated among all new parents is primarily a function of the increase in responses from new urban members. At T1, new urban members generated significantly fewer responses than did short or long-time members. At T2, these new urban subjects offered significantly more solutions than they had at T1, thus supporting the prediction that such increases would occur. The pattern among new rural respondents, though not significant, is also in the predicted direction.

The expectation that ongoing members, particularly long-time parents, would also increase the number of alternatives provided and would probably offer the greatest number of solutions is not supported by the data for this item.

1.3.2 Types of solutions: first response

Table IV-1c. "The child grabs something in store": distribution of first responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	25	6	8	11	33	8	14	11
	%	(18)	(23)	(14)	(22)	(24)	(31)	(24)	(22)
Distraction	N	4	-	3	1	3	-	3	-
	%	(3)	-	(5)	(2)	(2)	-	(5)	-
Negative reinforcement without punishment	N	73	11	32	30	72	10	32	30
	%	(54)	(42)	(55)	(59)	(53)	(38)	(55)	(59)
Positive reinforcement	N	26	5	14	7	19	7	5	7
	%	(19)	(19)	(24)	(14)	(14)	(27)	(9)	(14)
Threaten	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Physical punishment	N	7	4	1	2	7	1	4	2
	%	(5)	(15)	(2)	(4)	(5)	(4)	(7)	(4)
Other	N	-	-	-	-	1	-	-	1
	%	-	-	-	-	(1)	-	-	(2)
Base:		135	26	58	51	135	26	58	51

Table IV-1d. "The child grabs something in store": distribution of first responses - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	12 (16)	1 (7)	4 (14)	7 (21)	24 (32)	4 (28)	8 (28)	12 (36)
Distraction	N %	8 (11)	2 (14)	2 (7)	4 (12)	6 (8)	2 (14)	2 (7)	2 (6)
Negative reinforcement without punishment	N %	41 (55)	9 (64)	13 (46)	19 (57)	36 (48)	6 (43)	13 (46)	17 (52)
Positive reinforcement	N %	9 (12)	1 (7)	5 (18)	3 (9)	6 (8)	1 (7)	3 (11)	2 (6)
Threaten	N %	- -	- -	- -	- -	1 (1)	- -	1 (4)	- -
Physical punishment	N %	5 (7)	1 (7)	4 (14)	- -	2 (3)	1 (7)	1 (4)	- -
Other	N %	- -	- -	- -	- -	- -	- -	- -	- -
Base:		75	14	28	33	75	14	28	33

In the Chi-square analyses performed on the data presented in this table, comparisons are made between those parents responding with a solution scored explanation, distraction, and negative reinforcement with those reporting positive reinforcement, threat of punishment and physical punishment at T1 and T2. Explanation, distraction and negative reinforcement of the behavior are grouped together as more adaptive and more educative responses; inadvertent positive reinforcement of negative behavior and various forms of punitive action are grouped together as less adaptive responses. "Other" responses were excluded from the analysis.

Length of membership produced no significant differences in terms of the type of solution chosen as a first response to the situation. Similarly, no significant differences occurred among any sub-group from T1 to T2. At T2, however, highly involved urban parents offered solutions of explanation, distraction or negative reinforcement with significantly greater frequency than did less involved urban subjects. All other analyses performed on the involvement data for type of first response yielded no significant findings.

The first response of the majority of respondents involved some form of negative reinforcement. That is, parents either removed the item from the child or removed the child from the store. Relatively few mothers reported that they would threaten or physically punish their children as a first alternative (5% urban and 4% rural at T2).

The percentage of parents reporting use of explanation as a first solution increased slightly from T1 to T2. This increase is consistent across all groups, except the long-time urban parents.

Overall, the number of persons suggesting positive reinforcement of the behavior as a first response decreased at T2. The exception was new urban parents, among whom a slight increase occurred. Some parents who offered this as a first solution, did so with the inclusion of stipulations. One mother said that "if it's good for them to eat and they are supposed to have it, then I am supposed to buy it." Another parent made a distinction between items, "I would buy food, but not a toy." Presumably, few PCC parents can afford to buy items at whim and the question often then becomes more one of finances than actual parenting. "I always ask my children if they think it's worth the money," said one mother who explained that she felt it was important for the children to understand the family's economic condition. Another mother, who did not think that buying the unintended item served to reinforce the child's negative behavior, also stressed finances, "it depends upon how much it costs. If it's too expensive for a baby, I won't buy it."

Few mothers thought of distracting the child and turning his attention elsewhere. This can be a useful solution with younger children who do not understand explanations and are likely to scream unpleasantly if the item is simply removed. In this vein, one mother suggested a solution that combines explanation with distraction: "I might try to explain why I will not buy the item and then I will try to substitute an item that is already in the cart. I try to make that item appealing. For example, if I bought bananas, I would tell them all about the delicious banana pudding I am going to make."

1.3.3. Types of solutions: all responses

Table IV-1e. "The child grabs something in store": distribution of all responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL**	NEW	SHORT**	LONG	TOTAL**	NEW	SHORT**	LONG
Explanation	N	41	9	15	17	68	14	30	24
	%	(14)	(19)	(11)	(15)	(23)	(25)	(22)	(23)
Distraction	N	14	3	6	5	23	4	13	6
	%	(5)	(6)	(5)	(4)	(8)	(7)	(10)	(6)
Negative reinforcement without punishment	N	110	17	47	46	97	13	44	40
	%	(38)	(36)	(36)	(40)	(33)	(23)	(32)	(38)
Positive reinforcement	N	68	8	37	23	36	10	13	13
	%	(23)	(17)	(28)	(20)	(12)	(18)	(10)	(12)
Threaten	N	7	-	4	3	6	2	1	3
	%	(2)	-	(3)	(3)	(2)	(4)	(1)	(3)
Physical punishment	N	53	10	22	21	50	12	26	12
	%	(18)	(21)	(17)	(18)	(17)	(21)	(19)	(11)
Other	N	-	-	-	-	17	1	9	7
	%	-	-	-	-	(6)	(2)	(7)	(7)
Base: total response		293	47	131	115	297	56	136	105

**Chi-square significant at .01 level.

Table IV-1f. "The child grabs something in store": distribution of all responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT*	LONG	TOTAL	NEW	SHORT*	LONG
Explanation	N	25	4	9	12	40	6	15	19
	%	(16)	(14)	(15)	(18)	(25)	(20)	(26)	(27)
Distraction	N	20	5	5	10	20	5	7	8
	%	(13)	(18)	(8)	(15)	(13)	(17)	(12)	(11)
Negative reinforcement without punishment	N	52	11	17	24	49	8	17	24
	%	(34)	(39)	(28)	(36)	(31)	(27)	(30)	(34)
Positive reinforcement	N	33	5	16	12	16	4	8	4
	%	(21)	(18)	(27)	(18)	(10)	(13)	(14)	(6)
Threaten	N	7	1	2	4	10	2	4	4
	%	(5)	(4)	(3)	(6)	(6)	(7)	(7)	(6)
Physical punishment	N	17	2	11	4	17	4	5	8
	%	(11)	(7)	(18)	(6)	(11)	(13)	(9)	(11)
Other	N	-	-	-	-	5	1	1	3
	%	-	-	-	-	(3)	(3)	(2)	(4)
Base: total responses		154	28	60	66	157	30	57	70

*Chi-square significant at .05 level.

The chi-square analysis performed on the distribution of all responses maintained the same format as those performed for first responses. That is, responses of explanation, distraction and negative reinforcement were compared to those of positive reinforcement, threat of punishment and physical punishment. Here too, a significant difference occurred between highly and less involved urban subjects at T2. The highly involved parents were more likely to choose the more adaptive solutions to the situation at hand than were the low involved parents.

As Tables IV-1 e&f show, significant differences occurred between T1 and T2 among the total urban sample and among both urban and rural short-time members. The significant differences represent an increase (in T2) in the number of respondents reporting solutions in the first cluster, i.e., explanation, distraction and negative reinforcement. Although not reaching statistical significance, all other categories of parents reported response patterns in the same general direction. The only exception is new rural parents whose reports of responses within the first cluster remained virtually the same.

While relatively few mothers mention punishment as a first solution, a far greater number eventually think of resorting to physical punishment. In fact, among urban mothers, physical punishment is the third most frequently mentioned response alternative. However, a shift has occurred. At T1, physical punishment was a more popular response among urban parents than was explanation; at T2 the reverse is true. Among all respondents, the use of explanation as a means of solving the problem situation has increased.

One mother who attempts to use explanation responded: "I explain why they can't have the thing. There are other ways of getting to a child -- whipping doesn't do it. They comprehend more than we think they do."

The idea that children can understand was not subscribed to by all mothers. A rural parent with several children replied: "It's no use explaining and I don't have the time." While this mother admitted to being somewhat harried and pressured for time amidst her numerous daily chores, others felt that it was important to offer some form of explanation, no matter how limited: "I'd talk to him gently and if he doesn't put it back, I'd take him into a back room and tear him up, that's the way I do my kids."

After offering solutions to deal with the situation at hand, some mothers made mention of alternatives they would use in the future in an effort to avoid recurrence of the problem. For the most part, these responses, coded under "other" on the Tables, all amounted to leaving the child at home when a shopping trip was necessary. Said one mother whose first response was to spank the child: "I would make him stay in the car or at home from then on. I'd take away his pleasures like soft drinks or candy bars." Another mother who had first suggested explanation and then distraction, finally said, "The truth is, I never go to the grocery store with my children unless my husband is with me for moral support."

1.3.4. Age and context - relevant responses: Time 2

Table IV-1g. "The child grabs something in the store:" age appropriate response; understands emotional needs of child/context of situation.

			URBAN				RURAL			
RESPONSES			TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
AGE APPROPRIATE RESPONSE										
	Yes	N	15	1	8	6	2	1	-	1
		%	(11)	(4)	(14)	(12)	(3)	(7)	-	(3)
	No	N	120	25	50	45	73	13	28	32
		%	(89)	(96)	(86)	(88)	(97)	(93)	(100)	(97)
UNDERSTANDS EMOTIONAL NEEDS OF CHILD/CONTEXT OF SITUATION										
	Yes	N	6	2	2	2	-	-	-	-
		%	(4)	(8)	(4)	(4)	-	-	-	-
	No	N	129	24	56	49	75	14	28	33
		%	(96)	(92)	(96)	(96)	(100)	(100)	(100)	(100)
Base			135	26	58	51	75	14	28	33

Only eight percent of the total sample mentioned that the solution chosen would depend upon the age of the child and only 3% indicated that the solution would depend upon either the emotional needs of the child or the context of the situation.

One mother who expressed an awareness that solution behavior might be age-dependent responded: "If the child is in the basket, I can push the basket away. If he's older, I can slap his hand and tell him 'no, he can't have it.'"

As can be seen from the data, the presentation of such age-dependent alternatives was rare.

1.4 Teaching danger avoidance

The second item was "How do you go about teaching a baby not to do something that can hurt him?" In the pretest, this very general question was followed with a couple of examples, e.g., going near a hot stove or running in the street. These were omitted from the final instrument so as not to restrict respondents' freedom of choice by illustrations.

A problem in coding the data for this item was that the example chosen can determine to some extent the type of solution offered. For instance, in teaching fire avoidance a mother can put her child's hand near a flame or hot object to let him feel how uncomfortable the heat is. Some mothers even allowed their children to be hurt in minor situations. These solutions would be unacceptable in the case of teaching a child not to run into the street or not to swallow possibly poisonous substances. It can be reasoned, however, that a mother who knows effective ways of teaching her children to avoid harm will select instances through which those methods may be communicated to the interviewer. Seven codes were developed:

- EXPLANATION:

  Verbal explanations of the danger of the object or situation.

- DEMONSTRATION:

  Approximating the danger for the child, acting out a situation of mock harm.

- DISTRACTION:

  Occupying the child elsewhere.

- REMOVAL:

  Removing the object to a safe place or removing the child from the object and keeping an eye on him.

- VERBAL DISAPPROVAL:

  Telling the child not to do it.

- PHYSICAL PUNISHMENT

- IGNORING:

  Taking no counter-measure at all, allowing the child to be hurt, presumably in situations that are not very serious.

1.4.1 The number of solutions

Table IV-2a. Danger avoidance; distribution of number of solutions - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	24	4	13	7	26	6	11	9
	%	(18)	(15)	(22)	(14)	(19)	(23)	(19)	(18)
Two responses	N	60	13	24	23	76	14	33	29
	%	(44)	(50)	(41)	(45)	(56)	(54)	(57)	(57)
Three responses	N	46	8	19	19	31	6	12	13
	%	(34)	(31)	(33)	(37)	(23)	(23)	(21)	(25)
Four responses	N	5	1	2	2	2	-	2	-
	%	(4)	(4)	(3)	(4)	(1)	-	(3)	-
Mean number of solutions		2.24	2.23	1.84	2.31	2.07	2.00	2.09	2.08
S.D.		.78	.75	.81	.75	.69	.68	.72	.65
Base		135	26	58	51	135	26	58	51

t1-2= 2.06; P=<.05
t2-3=-3.11; P=<.01
t2-5=-1.75; P=<.05

Table IV-2b. Danger avoidance; distribution of number of solutions - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	13	2	5	6	12	3	4	5
	%	(17)	(14)	(18)	(18)	(16)	(21)	(14)	(15)
Two responses	N	38	6	13	19	42	7	18	17
	%	(51)	(43)	(46)	(58)	(56)	(50)	(64)	(52)
Three responses	N	18	4	9	5	19	2	6	11
	%	(24)	(29)	(32)	(15)	(25)	(14)	(21)	(33)
Four responses	N	6	2	1	3	2	2	-	-
	%	(8)	(14)	(4)	(9)	(3)	(14)	-	-
Mean number of solutions		2.23	2.43	2.21	2.15	2.15	2.21	2.07	2.18
S.D.		.82	.90	.77	.82	.71	.94	.59	.67
Base		75	14	28	33	75	14	28	33

At T1, short-time urban parents offered significantly fewer solutions than did either new or long-time urban respondents. However, at T2, there was a significant increase in terms of the number of responses generated by this subgroup. The only other subgroup to increase at all in this area was long-time rural subjects, and this increase was slight. In general, the mean number of solutions generated by any subgroup decreased from T1 to T2. This is primarily the result of an increase in the number of subjects giving two alternatives and a decrease in the three or more solutions category. This is particularly true among urban respondents, the sample showing the greatest decrease in mean number of solutions. The data are not supportive of the expectation that new parents would increase in the number of alternatives presented and that long-time parents would offer the greatest number of solutions.

1.4.2 Types of solutions: first response

Table IV-2c. Danger avoidance; distribution of first responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	49	7	23	19	67	14	28	25
	%	(36)	(27)	(40)	(37)	(50)	(54)	(48)	(49)
Teaching by demonstration	N	25	7	9	9	33	4	14	15
	%	(18)	(27)	(16)	(18)	(24)	(15)	(24)	(29)
Distraction	N	1	-	-	1	2	2	-	-
	%	(1)	-	-	(2)	(1)	(8)	-	-
Removal of object	N	16	6	7	3	13	5	5	3
	%	(12)	(23)	(12)	(6)	(10)	(19)	(9)	(6)
Verbal disapproval	N	26	3	11	12	2	-	1	1
	%	(19)	(12)	(19)	(24)	(1)	-	(2)	(2)
Physical punishment	N	13	2	6	5	7	1	3	3
	%	(10)	(8)	(10)	(10)	(5)	(4)	(5)	(6)
Ignore	N	5	1	2	2	11	-	7	4
	%	(4)	(4)	(3)	(4)	(9)	-	(12)	(8)
Other	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Base		135	26	58	51	135	26	58	51

Table IV-2d. Danger avoidance; distribution of first responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	24	2	6	16	40	8	17	15
	%	(32)	(14)	(21)	(48)	(53)	(57)	(61)	(45)
Teaching by demonstration	N	9	2	5	2	5	1	2	2
	%	(12)	(14)	(18)	(6)	(7)	(7)	(7)	(6)
Distraction	N	6	1	-	5	3	-	1	2
	%	(8)	(7)	-	(15)	(4)	-	(4)	(6)
Removal of object	N	6	1	3	2	12	2	2	8
	%	(8)	(7)	(11)	(6)	(16)	(14)	(7)	(24)
Verbal disapproval	N	15	3	9	3	4	1	2	1
	%	(20)	(21)	(32)	(9)	(5)	(7)	(7)	(3)
Physical punishment	N	10	4	3	3	5	2	3	-
	%	(13)	(29)	(11)	(9)	(7)	(14)	(11)	-
Ignore	N	5	1	2	2	5	-	1	4
	%	(7)	(7)	(7)	(6)	(7)	-	(4)	(12)
Other	N	-	-	-	-	1	-	-	1
	%	-	-	-	-	(1)	-	-	(3)
Base		75	14	28	33	75	14	28	33

In order to perform chi-square analyses for this item, categories of response were coded explanation, teaching by demonstration, removal of object and verbal disapproval were compared to those whose responses were to physically punish the child or ignore the situation. Again, the first set of responses are grouped together because they are judged to represent a more constructive approach to the problem than do the second set.

Using these categories of response for comparison, a significant difference was produced for the solutions offered by highly and less involved urban respondents at T1. As with the situation in which the child grabs an unwanted item, highly involved parents were more likely to choose more adaptive means of handling the behavior suggested in this particular situation than were less involved parents.

In terms of longevity, although the number of solutions generated did not increase in T2, there was a shift in the type of solution offered as a first response. A greater proportion of parents reported explanation, teaching by demonstration and removal of the object as a first choice in T2 while the proportion of parents suggesting physical punishment decreased. Among long-time parents, the pattern appears to be to give more adaptive first responses, but fewer answers overall. Perhaps this is a case in which more knowledgeable mothers feel that there is really only one good solution. When a child takes an unwanted item from the supermarket, he is causing an annoying interference. When he enters a situation of potential harm to himself, the matter is more serious. It may be a case of having the more potentially serious situation being considered more directly and precisely than the less important one.

Judging from the distribution of first responses, it appears that mothers consider it necessary to take an active and longer range approach to the situation. That is, fewer mothers reported at T2 that they would simply say "no" to the child as a means of protecting him from danger. Rather, they explain the situation to the child, either verbally or demonstratively, in an effort to avoid potential problems in the future. This seems to be especially true of urban parents. Seventy-four percent of the urban parents report either explanation or teaching as a first response in T2.

It is possible that the high proportion of respondents reporting explanation and teaching is a result of the subjects' interpretation of the item to mean how should one handle this situation. The interview setting allows for a degree of objectivity and remoteness that is not present in a situation of potential danger. That is, during an interview the parent has the opportunity to think about the appropriate means of dealing with a problem, the conditions of which she herself constructs. However, in actual situations of danger, the parent must often act immediately in order to avoid harm. While the proportion of parents who reported that they would in some way remove the object of danger or remove the child from the situation increased in T2, it is not as high as one might expect nor is it probably a fair indication of the number of persons who would actually respond in this manner given a real situation of potential danger.

1.4.3 Types of solutions: all responses

Table IV-2e. Danger avoidance; distribution of all responses - urban.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	72	12	34	26	86	16	37	33
	%	(24)	(21)	(27)	(22)	(31)	(31)	(30)	(31)
Teaching by demonstration	N	44	11	19	14	49	9	19	21
	%	(14)	(19)	(15)	(12)	(18)	(17)	(16)	(20)
Distraction	N	3	-	1	2	8	2	4	2
	%	(1)	-	(1)	(2)	(3)	(4)	(3)	(2)
Removal of object	N	45	11	20	14	42	8	20	14
	%	(15)	(19)	(16)	(12)	(15)	(15)	(16)	(13)
Verbal disapproval	N	33	5	13	15	8	1	3	4
	%	(11)	(9)	(10)	(13)	(3)	(2)	(2)	(4)
Physical punishment	N	76	14	29	33	52	8	23	21
	%	(25)	(24)	(23)	(28)	(19)	(15)	(19)	(20)
Ignore	N	19	4	7	8	31	7	15	9
	%	(6)	(7)	(6)	(7)	(11)	(13)	(12)	(8)
Other	N	10	1	3	6	3	1	-	2
	%	(3)	(2)	(2)	(5)	(1)	(2)	-	(2)
Base: total responses		302	58	126	118	279	52	121	106

Table IV-2f. Danger avoidance; distribution of all responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	37	7	13	17	53	9	21	23
	%	(22)	(20)	(21)	(24)	(33)	(29)	(36)	(32)
Teaching by demonstration	N	21	3	9	9	18	3	7	8
	%	(12)	(9)	(14)	(13)	(11)	(10)	(12)	(11)
Distraction	N	9	1	2	6	14	3	2	9
	%	(5)	(3)	(3)	(8)	(9)	(10)	(3)	(12)
Removal of object	N	18	4	8	6	29	7	8	14
	%	(11)	(12)	(13)	(8)	(18)	(22)	(14)	(19)
Verbal disapproval	N	28	5	15	8	7	2	2	3
	%	(17)	(15)	(24)	(11)	(4)	(6)	(3)	(4)
Physical punishment	N	31	9	11	11	21	6	10	5
	%	(18)	(26)	(18)	(15)	(13)	(19)	(17)	(7)
Ignore	N	15	3	3	9	17	-	8	9
	%	(10)	(9)	(5)	(13)	(10)	-	(14)	(12)
Other	N	8	2	1	5	2	1	-	1
	%	(5)	(6)	(2)	(7)	(1)	(3)	-	(1)
Base: total responses		167	34	62	71	161	31	58	72

The chi-square analyses performed on the data presented in Tables IV-2d and 2e utilized the same response categories as were developed for first solution responses. Involvement data for this item yielded a significant difference among rural respondents at T1. Here again, the difference was in the predicted direction, i.e., highly involved parents chose the more adaptive and educative solutions to the situation than did less involved parents. No other differences across involvement proved significant.

Differences across longevity subgroups diminish when all responses generated are distributed. With few exceptions, new and ongoing parents arrive at similar responses in similar proportions. Although physical punishment is mentioned slightly more often among urban than rural members, the response pattern across locale also shows few differences.

While an occasional mother would offer a first response such as: "if they touch a plug I whip them," for the most part, few mothers chose physical punishment as a first and only technique for dealing with situations of danger. Most often, punishment was used in conjunction with other solutions or as a final response when it became clear that the child might in fact be hurt. Said one exasperated mother: "I try to explain things to my kids, but you really can't talk to my children. Some kids you can explain to, but not mine. I tell them 'no,' I tell them it's dangerous, but they don't listen. Sometimes setting their tails on fire is the only way."

Ignoring the child's behavior or allowing him to be hurt presents a similar situation. While it is not a frequent first solution, some parents resort to this technique in the end: "My child used to cut up everything with a knife. I couldn't get him to stop. I finally told him to cut himself. He made a little cut and when he saw the blood he didn't play with the knife again."

The feeling that "experience is the best teacher" does not always necessitate the parent taking an active role in providing the experience: "I try not to scare my children. I try to make them understand the situation by having them think about what they know about it. I always ask them, 'what do you think will happen?' My son saw a kid run over - he's very careful now."

1.4.4 Age and context - relevant solutions: Time 2

Table IV-2g. Danger avoidance; age appropriate response - understands emotional needs of child/context of situation.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
AGE APPROPRIATE RESPONSE									
Yes	N	16	1	6	9	6	3	2	1
	%	(12)	(4)	(10)	(18)	(8)	(22)	(7)	(3)
No	N	119	25	52	42	69	11	26	32
	%	(88)	(96)	(90)	(82)	(92)	(78)	(93)	(97)
UNDERSTANDS EMOTIONAL NEEDS OF CHILD/CONTEXT OF SITUATION									
Yes	N	5	2	2	1	3	-	2	1
	%	(4)	(8)	(4)	(2)	(4)	-	(7)	(3)
No	N	130	24	56	50	72	14	26	32
	%	(96)	(92)	(96)	(98)	(96)	(100)	(93)	(97)
Base		135	26	58	51	75	14	28	33

Age appropriate responses were offered by only 10% of the total sample. For the most part, age appropriate responses usually entailed the removal of harmful objects as a precautionary measure:

"You can't depend on saying no and slapping their hands. They're just curious, especially the young ones. With them, the best thing to do is to try to get the dangerous object out of their way."

"What to do depends on how little they are. Keep your house 'childrenized' so that you don't have things they can't have in their reach."

Solutions that considered the context of the situation or the particular child's needs were offered by only 4% of the respondents. One mother said: "My child frightens very easily. He's a nervous baby. I don't wanna frighten him so I always talk to him with tenderness."

1.5 Nuisance termination

This item presents a situation that may be the most common of all, general irritating rowdiness: "Suppose that your baby is bugging you, e.g., turning his cup over, pulling things down, throwing things out of his crib and then yelling for them. How do you handle him?"

Some parents noted that the item seemed to specify a crib-age child. In such cases, interviewers loosened the instructions to include any child who is being a loud, demanding nuisance.

This item necessitated some codes not used with the two previous ones. In particular, responses of checking to see if something is wrong with the child, and of giving comfort and reassurance, where appropriate. Responses that could be construed as teaching -- explaining to the child why he should not misbehave -- were encountered in small measure at T1 and were thus merged with supportive, comforting response. Also, threats of punishment did not exceed the 2% level at T1 for either first or toal response and so these were merged into the verbal disapproval category.

In all, seven codes were employed:

- INVESTIGATION
  Looking to see if the child is wet, sick, hungry, etc.

- SUPPORTIVE
  Giving the child attention, including picking up, holding, rocking, talking to him.

- DISTRACTION
  Diverting his attention with a toy, a pacifier, a walk, taking him to another location.

- VERBAL DISAPPROVAL
  Yelling at the child, threatening punishment, shaming him, taking an authoritarian stance.

- ISOLATION
  Making him take a nap, putting him alone in a room, separating him from his things, withdrawing privileges.

- IGNORING
  Letting the child continue without any parental attention whatsoever.

- PHYSICAL PUNISHMENT

1.5.1 The number of solutions

Table IV-3a. Nuisance termination; distribution of the number of solutions - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	23	4	11	8	20	5	8	7
	%	(17)	(15)	(19)	(16)	(15)	(19)	(14)	(14)
Two responses	N	62	14	24	24	79	13	36	30
	%	(46)	(54)	(41)	(47)	(59)	(50)	(62)	(59)
Three responses	N	42	8	19	15	33	7	13	13
	%	(31)	(31)	(33)	(29)	(24)	(27)	(22)	(25)
Four responses	N	8	-	4	4	3	1	1	1
	%	(6)	-	(7)	(8)	(2)	(4)	(2)	(2)
Mean		2.26	2.15	2.28	2.29	2.14	2.15	2.12	2.16
S.D.			.66	.85	.82		.77	.65	.67
Base: number of respondents		135	26	58	51	135	26	58	51

Table IV-3b. Nuisance termination; distribution of the number of solutions - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	22	6	8	8	12	3	5	4
	%	(29)	(43)	(29)	(24)	(16)	(21)	(18)	(12)
Two responses	N	36	6	10	20	42	7	15	20
	%	(48)	(43)	(36)	(61)	(56)	(50)	(54)	(61)
Three responses	N	15	1	9	5	18	3	8	7
	%	(20)	(7)	(32)	(15)	(24)	(21)	(28)	(21)
Four responses	N	2	1	1	-	3	1	-	2
	%	(3)	(7)	(4)	-	(4)	(7)	-	(6)
Mean		1.96	1.78	2.11	1.91	2.16	2.14	2.11	2.21
S.D.			.86	.86	.62		.83	.67	.73
Base: number of respondents		75	14	28	33	75	14	28	33

$t_{3-6} = -1.77$; $P = < .05$

At T1, the pattern seen in the previous items in which urban parents offered the most alternatives is maintained. In T2 however, rural parents show a slight increase in the average number of responses generated so that subsample differences are obliterated. With the exception of long-time rural respondents, whose number of solutions increased significantly from T1 to T2, there were no other significant differences either within subsamples or over time.

1.5.2 Types of solutions: first response

Table IV-3c. Nuisance termination; distribution of first responses - urban.

		TIME 1				TIME 2			
RESPONSES		* TOTAL	NEW	SHORT	LONG	* TOTAL	NEW	SHORT	LONG
Investigation	N	15	2	7	6	17	1	4	12
	%	(11)	(8)	(12)	(12)	(13)	(4)	(7)	(24)
Supportive	N	25	4	9	12	29	7	14	8
	%	(19)	(15)	(16)	(24)	(22)	(27)	(24)	(16)
Distraction	N	14	1	8	5	24	4	12	8
	%	(10)	(4)	(14)	(10)	(18)	(15)	(21)	(16)
Isolation	N	27	6	9	12	15	3	8	4
	%	(20)	(23)	(16)	(24)	(11)	(12)	(14)	(8)
Verbal disapproval	N	21	5	11	5	7	1	1	5
	%	(15)	(19)	(19)	(10)	(5)	(4)	(2)	(10)
Ignore	N	8	1	3	4	24	6	11	7
	%	(6)	(4)	(5)	(8)	(18)	(23)	(19)	(14)
Physical punishment	N	25	7	11	7	16	2	8	6
	%	(19)	(27)	(19)	(14)	(12)	(8)	(14)	(12)
Other	N	-	-	-	-	3	2	-	1
	%	-	-	-	-	(2)	(8)	-	(2)
Base:		135	26	58	51	135	26	58	51

* Chi-square significant at .05 level.

Table IV-3d. Nuisance termination; distribution of first responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	* SHORT	LONG	TOTAL	NEW	* SHORT	LONG
Investigation	N	4	-	1	3	5	2	-	3
	%	(5)	-	(4)	(9)	(7)	(14)	-	(9)
Supportive	N	21	1	11	9	19	4	4	11
	%	(28)	(7)	(39)	(27)	(25)	(28)	(14)	(33)
Distraction	N	20	7	7	6	11	-	6	5
	%	(27)	(50)	(25)	(18)	(15)	-	(21)	(15)
Isolation	N	10	-	5	5	14	2	7	5
	%	(13)	-	(18)	(15)	(19)	(14)	(25)	(15)
Verbal disapproval	N	8	1	3	4	6	1	3	2
	%	(10)	(7)	(11)	(12)	(8)	(7)	(11)	(6)
Ignore	N	6	2	-	4	9	1	3	5
	%	(8)	(14)	-	(12)	(12)	(7)	(11)	(15)
Physical punishment	N	6	3	1	2	7	2	4	1
	%	(8)	(21)	(4)	(6)	(9)	(14)	(14)	(3)
Other	N	-	-	-	-	4	2	1	1
	%	-	-	-	-	(5)	(14)	(4)	(3)
Base:		75	14	28	33	75	14	28	33

* Chi-square significant at .05 level.

In order to perform the complement of chi-square analyses, response categories were collapsed so as to allow for a sufficient N in each cell. Responses coded investigation, supportive action, and distraction were compared with those coded isolation, verbal disapproval, ignoring child's behavior and physical punishment. The first set of responses was grouped together because they were judged to represent a more positive and adaptive approach to childish fretting than was the second set of responses.

At T2, the total urban sample reported more adaptive solutions (i.e., investigation, supportive and distraction) with significantly greater frequency than was true at T1. Such a change indicates movement toward a less punitive approach in dealing with the child's irritating behavior.

On the whole, the total rural response pattern shows no change over time. The new and short-time rural members did, however, show some interesting changes. At T1, 50% of the new rural subjects reported that they would attempt to distract the child as a first means of handling the situation. At T2, not one member of this group offered such a solution, although investigation and supportive behavior did become more popular responses. Among short-time members, there was a significant shift in response pattern in the opposite direction to what had been expected. That is, at T2, significantly more of the short-time members were relying upon second cluster responses (isolation, verbal disapproval, ignoring and physical punishment) as a first choice technique for terminating the child's annoying actions.

1.5.3 Types of solutions: all responses

Table IV-3e. Nuisance termination; distribution of all responses - urban.

		TIME 1				TIME 2			
RESPONSES		*** TOTAL	* NEW	* SHORT	LONG	*** TOTAL	* NEW	* SHORT	LONG
Investigation	N	28	4	10	14	28	2	8	18
	%	(9)	(7)	(8)	(12)	(10)	(4)	(6)	(16)
Supportive	N	45	10	18	17	52	11	23	18
	%	(15)	(18)	(14)	(14)	(18)	(20)	(19)	(16)
Distraction	N	33	3	16	14	50	11	23	16
	%	(11)	(5)	(12)	(12)	(17)	(20)	(19)	(14)
Isolation	N	61	16	23	22	41	8	19	14
	%	(20)	(28)	(17)	(19)	(14)	(14)	(15)	(13)
Verbal disapproval	N	35	5	19	11	18	2	4	12
	%	(11)	(9)	(14)	(9)	(6)	(4)	(3)	(11)
Ignore	N	36	7	17	12	47	13	17	17
	%	(12)	(12)	(13)	(10)	(16)	(23)	(14)	(15)
Physical punishment	N	67	11	29	27	45	6	26	13
	%	(22)	(20)	(22)	(23)	(16)	(11)	(21)	(12)
Other	N	-	-	-	-	8	3	3	2
	%	-	-	-	-	(3)	(5)	(2)	(2)
Base: total responses		305	56	132	117	289	56	123	110

* Chi-square significant at .05 level.
*** Chi-square significant at .001 level.

Table IV-3f. Nuisance termination; distribution of all responses - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	10	1	3	6	16	6	4	6
	%	(7)	(4)	(5)	(10)	(10)	(20)	(7)	(8)
Supportive	N	35	5	15	15	36	5	12	19
	%	(24)	(20)	(25)	(24)	(22)	(17)	(20)	(26)
Distraction	N	32	7	14	11	28	5	9	14
	%	(22)	(28)	(24)	(17)	(17)	(17)	(15)	(19)
Isolation	N	27	3	12	12	16	2	7	7
	%	(18)	(12)	(20)	(19)	(10)	(7)	(12)	(10)
Verbal disapproval	N	17	3	6	8	19	4	8	7
	%	(12)	(12)	(10)	(13)	(12)	(13)	(14)	(10)
Ignore	N	13	2	6	5	27	2	11	14
	%	(9)	(8)	(10)	(8)	(17)	(7)	(19)	(19)
Physical punishment	N	13	4	3	6	15	4	6	5
	%	(9)	(16)	(5)	(10)	(9)	(13)	(10)	(7)
Other	N	-	-	-	-	5	2	2	1
	%	-	-	-	-	(3)	(7)	(3)	(1)
Base: total responses		147	25	59	63	162	30	59	73

Chi-square comparisons were made between responses coded investigation, supportive behavior and distraction and responses coded verbal disapproval and physical punishment. Isolation and ignoring the child's actions were not included as responses in the analyses. It was felt that while these solutions might be relatively maladaptive as a first response, they were rather neutral as successive solutions. If after checking to see if there is anything wrong with the child, and then making an effort to provide him with attention and an interesting plaything, the child is still cranky, then ignoring the behavior may be the most adaptive solution.

Chi-squares were significant for new and short-time urban members as well as for the urban subsample as a whole. At T2, significantly fewer urban parents were resorting to punitive action as an alternative than was true at T1. No significant changes occurred among long-time urban parents or within the rural subsample. It is interesting to note, however, that the responses of these groups were similar in proportion to those of new and short-time urban members. That is, more long-time urban and rural respondents tended to select investigation, supportive behavior and distraction as a means of handling the situation in T1 and thus there were no significant changes over time.

The range of solutions within each category of response was wide. Most mothers select a combination of behaviors to handle the situation, often resorting to physical punishment when previous solutions were not effective or when the mothers' level of tolerance had been over-reached. The following illustrate the variety of alternatives presented:

> "Give him juice and water to relax him. I try to find out what's wrong with the baby before I start spanking."

> "I would change the child's environment. I try to find out what the child wants. Sometimes children act that way when they're tired."

"Explain to my child that he shouldn't do those things. If he does, I beat him."

"My children never play in a crib. When they're awake they're out of the bed. I have them help me. It's a lot easier keeping them busy that way than fighting them off."

"If they're acting like that, I find it usually works if mama spends some time with him. I give him paper to tear, things like old phone books."

"Tell her to stop. If she doesn't stop I take her over to my mama. She knows how to handle her."

"Take the kid out of the crib. If he's big enough to throw things out of the crib, he's big enough to be out. If the kid throws a toy out of the crib, put it in the closet so he can't have it. Pretty soon you'll have a closet full of toys, but that's O.K. -- the kid'll learn he can't throw things."

1.5.4 Age and context - relevant responses: Time 2

Table IV-3g. Nuisance termination; age appropriate response - understands emotional needs of child/context of situation.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
AGE APPROPRIATE RESPONSE									
Yes	N	13	3	7	3	9	2	4	3
	%	(10)	(12)	(12)	(6)	(12)	(14)	(14)	(9)
No	N	122	23	51	48	66	12	24	30
	%	(90)	(88)	(88)	(94)	(88)	(86)	(86)	(91)
UNDERSTANDS EMOTIONAL NEEDS OF CHILD/CONTEXT OF SITUATION									
Yes	N	16	4	5	7	5	1	1	3
	%	(12)	(15)	(9)	(14)	(7)	(7)	(4)	(9)
No	N	119	22	53	44	70	13	27	30
	%	(88)	(85)	(91)	(86)	(93)	(93)	(96)	(91)
Base		135	26	58	51	75	14	28	33

Ten percent of the entire sample reported responses that either took into account the age of the child, his emotional needs or the context of the situation.

Said one mother: "I might hit the older child, but the younger one doesn't understand, so I won't hit him."

A few perceptive mothers viewed the child's behavior as a response to their own frame of mind at the time: "He might be acting like that because of the mood that I'm in. I try to hold back my temper."

1.6 Nocturnal crying

"If you baby refuses to go to sleep when you put him down at night -- if he won't stop crying -- what do you do?"

Many mothers stated that they never had encountered the problem. Hence, a fair measure of make believe had to be encouraged. Seven codes were generated:

- INVESTIGATION
  Looking to see if the child is wet, sick, hungry, cold, etc.
- SUPPORTIVE
  Rocking, holding, cuddling, lying down with the child, taking the child into bed.
- VOCALIZATION
  Talking, singing, humming, etc.
- FEEDING
- TIRING OUT
  Letting the child stay up to play until he is tired.
- IGNORING
  Letting the child cry.
- PUNISHMENT
  Actual or threatened.

1.6.1 The number of solutions

Table IV-4a. Nocturnal crying; distribution of the number of solutions - urban.

RESPONSES		TIME 1				TIME 2			
		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	21	4	9	8	17	6	5	6
	%	(16)	(15)	(16)	(16)	(13)	(23)	(9)	(12)
Two responses	N	51	8	23	20	77	10	37	30
	%	(38)	(31)	(40)	(39)	(57)	(38)	(64)	(59)
Three responses	N	45	12	17	16	38	9	15	14
	%	(33)	(46)	(29)	(31)	(28)	(35)	(26)	(27)
Four responses	N	18	2	9	7	3	1	1	1
	%	(13)	(8)	(16)	(14)	(2)	(4)	(2)	(2)
Mean		2.44	2.46	2.45	2.43	2.20	2.19	2.21	2.20
S.D.			.84	.93	.91		.83	.61	.66
Base: number of respondents		135	26	58	51	135	26	58	51

Table IV-4b. Nocturnal crying; distribution of the number of solutions - rural.

RESPONSES		TIME 1 TOTAL	TIME 1 (1) NEW	TIME 1 (2) SHORT	TIME 1 (3) LONG	TIME 2 TOTAL	TIME 2 (4) NEW	TIME 2 (5) SHORT	TIME 2 (6) LONG
One response	N	13	2	7	4	13	3	4	6
	%	(17)	(14)	(25)	(12)	(17)	(21)	(14)	(18)
Two responses	N	26	4	7	15	40	7	17	16
	%	(35)	(29)	(25)	(45)	(53)	(50)	(61)	(48)
Three responses	N	20	6	8	6	18	3	7	8
	%	(27)	(43)	(29)	(18)	(24)	(21)	(25)	(24)
Four responses	N	16	2	6	8	4	1	-	3
	%	(21)	(14)	(21)	(24)	(5)	(7)	-	(9)
Mean		2.52	2.57	2.46	2.54	2.17	2.14	2.11	2.24
S.D.			.90	1.08	.99		.83	.62	.85
Base: number of respondents		75	14	28	33	75	14	28	33

Among all parents, the differences in the number of solutions generated did not vary considerably across longevity. This was true at both interview times although at T2 there was a tendency to offer fewer solutions. Although no differences were significant, it can be seen that this is the first item on which, at T1, rural parents generated more alternatives than did their urban counterparts. In addition, the greatest mean number of solutions was achieved by new rather than by ongoing members. This pattern is not maintained at T2. At this time urban parents once again offered the most solutions and the majority of parents gave only two responses.

1.6.2 Types of solution: first response

Table IV-4c. Nocturnal crying; distribution of first responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	38	8	13	17	55	6	23	26
	%	(28)	(31)	(22)	(33)	(41)	(23)	(40)	(51)
Supportive	N	35	7	21	7	32	7	14	11
	%	(26)	(27)	(36)	(14)	(24)	(27)	(24)	(22)
Vocalization	N	6	-	1	5	7	2	4	1
	%	(4)	-	(2)	(10)	(5)	(8)	(7)	(2)
Feeding	N	16	4	7	5	7	2	3	2
	%	(12)	(15)	(12)	(10)	(5)	(8)	(5)	(4)
Tire	N	12	3	5	4	10	3	5	2
	%	(9)	(12)	(9)	(8)	(7)	(12)	(9)	(4)
Ignore	N	23	4	9	10	22	5	8	9
	%	(17)	(15)	(16)	(20)	(16)	(19)	(14)	(18)
Punish	N	5	-	2	3	2	1	1	-
	%	(4)	-	(4)	(6)	(2)	(4)	(2)	-
Base:		135	26	58	51	135	26	58	51

Table IV-4d. Nocturnal crying; distribution of first responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	10	1	4	5	17	-	7	10
	%	(13)	(7)	(14)	(15)	(23)	-	(25)	(30)
Supportive	N	39	7	13	19	35	9	11	15
	%	(52)	(50)	(47)	(58)	(47)	(64)	(39)	(45)
Vocalization	N	2	1	1	-	7	1	3	3
	%	(3)	(7)	(4)	-	(9)	(7)	(11)	(9)
Feeding	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Tire	N	11	4	4	3	5	1	2	2
	%	(15)	(29)	(14)	(9)	(7)	(7)	(7)	(6)
Ignore	N	11	1	5	5	9	2	4	3
	%	(15)	(7)	(18)	(15)	(12)	(14)	(14)	(9)
Punish	N	2	-	1	1	2	1	1	-
	%	(3)	-	(4)	(3)	(3)	(7)	(4)	-
Base		74	14	28	33	75	14	28	33

Categories of responses were again collapsed in order to permit Chi-square analyses. Responses coded investigation, supportive behavior, vocalization and feeding were judged to be adaptive approaches to the situation and were thus compared to those responses coded tiring the child, ignoring the child's behavior and punishing the child. This latter set of responses were judged to be less adaptive approaches to handling a crying child who will not settle down to sleep.

No significant differences were produced by the data on involvement.

With few exceptions, the most striking differences occurred along the urban/rural dimension rather than that of longevity of membership. At T1, there were no significant differences in response pattern across the longevity variable of each subsample. When chi-square analyses were performed to compare the change in response for each level of longevity over time, again, no significant differences were found.

At both times, the combination of investigation and supportive behaviors constituted the first response pattern of the majority of mothers. However, there were urban/rural differences of note for each of these solutions. At both interview times, urban mothers were more likely to check to see if something was wrong with the child (28% at T1 and 41% at T2), than were rural parents (13% and 23%). At T2, investigation was the most common response of ongoing urban members; these respondents were twice as likely to check the child than were new urban members. While urban parents chose investigation as a first solution, their rural counterparts tended to provide comfort and/or support for the child (52% at T1; 47% at T2), as a first solution for handling the situation. In both cases however, the alternatives chosen are adaptive first responses to the situation.

At neither interview time did rural parents mention feeding the child as a first solution. At T1, rural parents, particularly new ones, were more likely to allow the child to stay up until he was ready to go to sleep than were urban parents.

While for the first time punishment does not appear as a major first response category, at both times, approximately 15% of the respondents reported that they would attempt to ignore the child's crying. Said one mother: "He's spoiled enough as it is. He just wants mama to pick him up -- I don't. I just let him holler til he goes to sleep."

1.6.3 Types of solutions: all responses

Table IV-4e. Nocturnal crying; distribution of all responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	72	13	29	30	78	12	33	33
	%	(22)	(20)	(20)	(24)	(26)	(21)	(26)	(29)
Supportive	N	76	16	37	23	63	11	28	24
	%	(23)	(25)	(26)	(18)	(21)	(19)	(22)	(21)
Vocalization	N	18	2	6	10	28	5	11	12
	%	(5)	(3)	(4)	(8)	(10)	(9)	(8)	(11)
Feeding	N	43	11	20	12	19	3	11	5
	%	(13)	(17)	(14)	(10)	(6)	(5)	(8)	(4)
Tire	N	37	8	17	12	25	7	12	6
	%	(11)	(12)	(12)	(10)	(8)	(12)	(9)	(5)
Ignore	N	67	11	28	28	58	13	25	20
	%	(20)	(17)	(20)	(22)	(20)	(23)	(20)	(18)
Punish	N	17	3	5	9	22	6	5	11
	%	(5)	(5)	(4)	(7)	(7)	(10)	(4)	(10)
Other	N	-	-	-	-	4	-	3	1
	%	-	-	-	-	(1)	-	(2)	(1)
Base: total responses		330	64	142	124	297	57	128	112

Table IV-4f. Nocturnal crying; distribution of all responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	27	5	9	13	22	1	9	12
	%	(14)	(14)	(13)	(15)	(13)	(3)	(15)	(16)
Supportive	N	66	12	22	32	46	10	15	21
	%	(35)	(33)	(32)	(38)	(28)	(33)	(25)	(28)
Vocalization	N	26	4	13	9	29	6	10	13
	%	(14)	(11)	(19)	(11)	(18)	(20)	(17)	(18)
Feeding	N	10	4	1	5	16	4	3	9
	%	(5)	(11)	(1)	(6)	(10)	(13)	(5)	(12)
Tire	N	28	7	12	9	13	1	8	4
	%	(15)	(19)	(17)	(11)	(8)	(3)	(14)	(5)
Ignore	N	23	4	9	10	17	5	7	5
	%	(12)	(11)	(13)	(12)	(10)	(17)	(12)	(7)
Punish	N	9	-	3	6	13	2	5	6
	%	(5)	-	(4)	(7)	(8)	(7)	(8)	(8)
Other	N	-	-	-	-	7	1	2	4
	%	-	-	-	-	(4)	(3)	(3)	(5)
Base: total responses		189	36	69	84	163	30	59	74

The same sets of response categories were used to perform chi-square analyses on the data presented in Tables IV-4e and f. Here again, no significant differences were found either in terms of longevity or involvement.

When all responses are considered, punishment still remains relatively low as an option to handling the situation. In this instance, parents are more likely to investigate, comfort or speak to the child in an effort to help him go to sleep.

Ignoring the child's behavior was a more common second or third response than it was a first. After making certain that the child was not wet or hungry, one mother said that: "I just lock the door and let him cry himself to sleep. I know there's nothing wrong with him and crying is good for the lungs." However, for some mothers the sound of the baby crying is difficult to accept. One such parent said: "I can't stand to hear her cry. I can't get a thing done with all that noise. When she gets like that I just take her out and let her crawl around or watch T.V. She usually falls asleep on the floor and I bring her back to her crib." A mother who used the same technique did so for different reasons: "If he's not tired there's no use in trying to force him to sleep."

For many parents, attention involved giving the child a bath; several mothers mentioned that they used the bath to relax the child. Said one: "If I feel he's nervous, I give him a hot bath and grease him down. I know he'll go to sleep then."

Not every parent wanted to spend the time that might be necessary to settle the child for sleep. One mother said: "I just yell at the child and tell 'em to keep quiet. I've spent all day with him and now it's time for him to sleep." Another mother said that she tells her children that "somebody outside is going to come and get them if they don't sleep. That does it." One mother, after offering her suggestions for handling the situation finally said: "children is just a lot of trouble."

1.6.4 Age and context - relevant responses: Time 2

Table IV-4g. Nocturnal crying; age appropriate response - understands emotional needs of child/context of situation.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
AGE APPROPRIATE RESPONSE									
Yes	N	10	-	6	4	10	1	5	4
	%	(7)	-	(10)	(8)	(13)	(7)	(18)	(12)
No	N	125	26	52	47	65	13	23	29
	%	(93)	(100)	(90)	(92)	(87)	(93)	(82)	(88)
UNDERSTANDS EMOTIONAL NEEDS OF CHILD/CONTEXT OF SITUATION									
Yes	N	21	4	6	11	10	-	3	7
	%	(16)	(15)	(10)	(22)	(13)	-	(11)	(21)
No	N	114	22	52	40	65	14	25	26
	%	(84)	(85)	(90)	(78)	(87)	(100)	(89)	(79)
Base		135	26	58	51	75	14	28	33

Relatively few parents considered either the age (10%) of the child or the context of the situation (15%) in determining their responses. Among those parents who did, considerations of this nature were more likely to occur to ongoing members. Twenty-one percent of all long-time members offered solutions that took into account either the emotional needs of the child or the particular situation. Illustrative of this was the response of one such mother: "I know my child - if she's crying like that it's because she needs attention and wants to receive affection." From another parent: "He usually cries if he hasn't seen me all day. It's his way of letting me know I haven't paid enough attention to him. When it happens, I set by his bed and talk to him til he goes to sleep."

In terms of age, some mothers mentioned that while they might give extra attention to a baby they would not do the same for an older child. One mother, who provided attention for both older and younger children made a differentiation in terms of the type of attention she would give: "I'll hold the baby for a while and maybe give him a bottle. I read a story to the big boy."

1.7 Sharing behavior

"If your baby is playing with another child, and only wants what the other child has, what do you do? How do you teach him to share?"

Seven codes were developed for this item:

- EXPLANATION

  Verbal explanation about why sharing, taking turns, is important.

- DISTRACTION

  Attempts to get the child involved in something else.

- REMOVAL OF TOY

  Neither child is allowed to play with the toy.

- VERBAL DISAPPROVAL
- TERMINATION OF CONTACT

  The children are separated and/or the offending child is removed.
- IGNORING BEHAVIOR
- PHYSICAL PUNISHMENT

1.7.1 The number of solutions

Table IV-5a. Sharing behavior; distribution of the number of solutions - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	53	8	23	22	28	6	9	13
	%	(39)	(31)	(40)	(43)	(21)	(23)	(16)	(25)
Two responses	N	46	10	22	14	74	13	35	26
	%	(34)	(38)	(38)	(27)	(55)	(50)	(60)	(51)
Three responses	N	31	8	11	12	29	5	12	12
	%	(23)	(31)	(19)	(24)	(21)	(19)	(21)	(24)
Four responses	N	5	-	2	3	4	2	2	-
	%	(4)	-	(3)	(6)	(3)	(8)	(3)	-
Mean		1.91	2.00	1.86	1.92	2.07	2.12	2.12	1.98
S.D.			.78	.84	.95		.85	.70	.70
Base: number of respondents		135	26	58	51	135	26	58	51

t2-5= -1.80; P=<.05

Table IV-4b. Sharing behavior; distribution of the number of solutions - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	26	4	9	13	16	4	6	6
	%	(35)	(29)	(32)	(39)	(21)	(29)	(21)	(18)
Two responses	N	34	8	13	13	41	5	19	17
	%	(45)	(57)	(46)	(39)	(55)	(36)	(68)	(52)
Three responses	N	14	2	6	6	14	4	3	7
	%	(19)	(14)	(21)	(18)	(19)	(29)	(11)	(21)
Four responses	N	1	-	-	1	4	1	-	3
	%	(1)	-	-	(3)	(5)	(7)	-	(9)
Mean		1.87	1.86	1.89	1.85	2.08	2.14	1.89	2.21
S.D.			.64	.72	.82		.91	.56	.84
Base: number of respondents		75	14	28	33	75	14	28	33

t3-6= -1.74; P=<.05
t5-6= -1.69; P=<.05

With the exception of rural short-time parents whose mean number of solutions remained stable from T1 to T2, all other longevity subgroups offered a greater number of alternatives in T2. Statistically significant differences over time occurred among short-time urban and long-time rural parents. Within subsamples, the only significant difference was between short-time and long-time rural members at T2; long-time parents generated more alternatives than did short-time parents. Although not statistically significant, it is interesting to note that new parents in both subsamples generally offered as many, if not more, solutions than did ongoing parents at both interview times.

1.7.2 Types of solutions: first response

Table IV-5c. Sharing behavior; distribution of first responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	59	9	28	22	77	16	35	26
	%	(44)	(35)	(48)	(43)	(57)	(62)	(60)	(51)
Distraction	N	26	9	12	5	21	5	9	7
	%	(19)	(35)	(21)	(10)	(16)	(19)	(16)	(14)
Removal of toy	N	7	2	2	3	10	1	2	7
	%	(5)	(8)	(3)	(6)	(7)	(4)	(3)	(14)
Verbal disapproval	N	40	5	16	19	8	1	4	3
	%	(30)	(19)	(28)	(37)	(6)	(4)	(7)	(6)
Separate children	N	2	1	-	1	8	-	3	5
	%	(2)	(4)	-	(2)	(6)	-	(5)	(10)
Ignore	N	-	-	-	-	4	-	3	1
	%	-	-	-	-	(3)	-	(5)	(2)
Physical punishment	N	1	-	-	1	-	-	-	-
	%	(1)	-	-	(2)	-	-	-	-
Other	N	-	-	-	-	7	3	2	2
	%	-	-	-	-	(5)	(12)	(3)	(4)
Base		135	26	58	51	135	26	58	51

Table IV-5d. Sharing behavior; distribution of first responses - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	33	7	15	11	36	7	12	17
	%	(44)	(50)	(54)	(33)	(47)	(50)	(43)	(52)
Distraction	N	28	2	7	19	22	4	9	9
	%	(37)	(14)	(25)	(58)	(29)	(28)	(32)	(27)
Removal of toy	N	-	-	-	-	5	3	1	1
	%	-	-	-	-	(7)	(21)	(4)	(3)
Verbal disapproval	N	12	5	5	2	7	-	3	4
	%	(16)	(36)	(18)	(6)	(9)	-	(11)	(12)
Separate children	N	1	-	1	-	1	-	-	1
	%	(1)	-	(4)	-	(1)	-	-	(3)
Ignore	N	1	-	-	1	2	-	2	-
	%	(1)	-	-	(3)	(3)	-	(7)	-
Physical punishment	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Other	N	-	-	-	-	2	-	1	1
	%	-	-	-	-	(3)	-	(4)	(3)
Base		75	14	28	33	75	14	28	33

The chi-square analyses performed on these data compared responses coded explanation and distraction with those coded removal of toy, separation, ignoring the behavior and physically punishing the child. While the first set of responses were considered to comprise more adaptive approaches than were the second, verbal disapproval was not included in either. Verbal disapproval was considered to be a rather neutral first response to handling the situation at hand. It was felt that telling the child not to continue his behavior without further explanation was neither an educative nor a punitive approach in attempting to teach the child to share.

The analyses of both involvement and longevity data produced no significant differences in the types of responses offered as a first solution.

Among all respondents at T2, the single most frequently used response category was explanation. With the exception of short-time rural parents, 43% of whom reported this response, the majority of parents said that they would try to explain the importance of sharing as their first method of handling the situation. At T1, this alternative was more commonly chosen by ongoing urban parents than by new urban members; at T2 these differences across longevity diminished. In fact, at T2, new urban members report using this method more often than do any other subgroup.

Overall, distraction is the next most popular alternative as a first response. This is particularly true among short-time rural members. Distraction is an especially effective technique to use with young children who may not understand either the explanation or the reason why the toy may not be available to them.

While 21% of the short-time rural respondents reported removing the toy from both children as a first response, for the most part, the proportion of parents offering solutions other than explanation or distraction was relatively small. Not a single parent suggested that they would physically punish the child as a first response in T2.

1.7.3 Types of solutions: all responses

Table IV-5e. Sharing behavior; distribution of all responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	90	18	39	33	93	18	41	34
	%	(35)	(35)	(36)	(34)	(33)	(33)	(33)	(34)
Distraction	N	61	15	27	19	61	15	29	17
	%	(24)	(29)	(25)	(19)	(22)	(27)	(24)	(17)
Removal of toy	N	20	4	11	5	31	6	14	11
	%	(8)	(8)	(10)	(5)	(11)	(11)	(11)	(11)
Verbal disapproval	N	46	6	19	21	23	3	6	14
	%	(18)	(12)	(18)	(21)	(8)	(5)	(5)	(14)
Separate children	N	18	3	5	10	39	9	17	13
	%	(7)	(6)	(5)	(10)	(14)	(16)	(14)	(13)
Ignore	N	3	1	1	1	9	-	6	3
	%	(1)	(2)	(1)	(1)	(3)	-	(5)	(3)
Physical punishment	N	7	1	3	3	12	1	6	5
	%	(3)	(2)	(3)	(3)	(4)	(2)	(5)	(5)
Other	N	13	4	3	6	11	3	4	4
	%	(5)	(8)	(3)	(6)	(4)	(5)	(3)	(4)
Base: total responses		258	52	108	98	279	55	123	101

Table IV-5f. Sharing behavior; distribution of all responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Explanation	N	48	8	18	22	48	9	16	23
	%	(34)	(31)	(34)	(36)	(31)	(30)	(30)	(32)
Distraction	N	42	6	14	22	49	9	17	23
	%	(30)	(23)	(26)	(36)	(31)	(30)	(32)	(32)
Removal of toy	N	10	1	5	4	12	3	5	4
	%	(7)	(4)	(9)	(7)	(8)	(10)	(9)	(5)
Verbal disapproval	N	17	5	8	4	13	1	3	9
	%	(12)	(19)	(15)	(7)	(8)	(3)	(6)	(12)
Separate children	N	10	1	4	5	12	2	3	7
	%	(7)	(4)	(8)	(8)	(8)	(7)	(6)	(10)
Ignore	N	3	1	1	1	5	-	4	1
	%	(2)	(4)	(2)	(2)	(3)	-	(8)	(1)
Physical punishment	N	7	4	1	2	10	5	3	2
	%	(5)	(15)	(2)	(3)	(6)	(17)	(6)	(3)
Other	N	3	-	2	1	7	1	2	4
	%	(2)	-	(4)	(2)	(4)	(3)	(4)	(5)
Base: total responses		140	26	53	61	156	30	53	73

The sets of response categories were modified in order to perform chi-square analyses on the data for all solutions generated. For these data, responses coded explanation and distraction were compared to those of ignoring the child's behavior and physical punishment. Verbal disapproval was once again excluded from the analyses for reasons previously discussed, in addition to separating the children and removing the toy. While termination of contact and removal of the object were considered somewhat maladaptive as a first response to the situation, it was felt that they attained a level of neutrality when other alternatives had been previously attempted. Such analyses produced no significant differences either in terms of the involvement or longevity data.

The most frequently used response when all solutions generated are considered remains explaining to the child why toys should be shared and encouragement of turn-taking behavior. One mother said that she found teaching the importance of sharing much easier when "I include myself in the turn-taking. The children like to have me play with them and they like to have me use their toys." Explanation often entailed some kind of teaching behavior, but it did not always involve the parent. Illustrative of this point are the following:

> "They learn better from other children than from me explaining."

> "I let the bigger children show the smaller children how to play."

> "I got 16 kids. I taught the oldest one how to share and she taught the others. When there are 16 kids they gotta learn to share."

Distracting the child's attention was an option selected by one-quarter of the parents at T2. While many parents reported that they would search for another toy that the child might enjoy, several parents said that they prepare for just such contingencies: "I make sure that there are enough toys for both children to play with." A good number of mothers said that, particularly when their own children are playing together: "I keep two of most toys around. That way nobody has to fight over it."

Some parents did not feel that they should teach their children to share or that explaining the situation had to necessarily result in both children using the item. The following examples serve to illustrate these feelings:

"Tell her it's not hers and if the other child wants to play with the toy she has to let her."

"I don't think it's a good policy for children to share everything."

"If it's food, I teach them to break it. If it's a toy, I have each one play with their own."

"I don't force my children to share. I don't encourage my children to play with other children's toys. I like them to have their own so they can say, 'this is mine.'"

If it did not seem that the situation was going to be solved equitably, parents then appeared to resort to separating the children or removing the toy from both children. Some parents mentioned that these were techniques they used with their own children, but could not use when another person's child was involved. These two methods were used more frequently by urban than rural parents.

Verbal disapproval, i.e., saying "no, don't do that" without further explanation, ignoring the behavior and physical punishment were used less often in response to this situation than to others. Although verbal disapproval is used more often by long-time parents than by any other subgroup, the proportion of parents reporting any of the three above-mentioned categories is small enough to suggest that parents feel it is necessary to react in a manner that will better ensure the termination of this type of undesirable social behavior. That is, parents seem less likely to ignore or tolerate non-sharing actions than they do annoying or irritating behavior. While parents appear to be able to ignore a child who is a nuisance at home, they are not as ready to allow a child's poor behavior to impinge on his relations with others.

1.7.4 Age or context-relevant responses: Time 2

Table IV-5g. Sharing behavior; age appropriate response - understands emotional needs of child/context of situation.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
AGE APPROPRIATE RESPONSE									
Yes	N	15	3	7	5	7	1	3	3
	%	(12)	(12)	(12)	(12)	(9)	(7)	(11)	(9)
No	N	119	23	51	45	68	13	25	30
	%	(88)	(88)	(88)	(88)	(91)	(93)	(89)	(91)
UNDERSTANDS EMOTIONAL NEEDS OF CHILD/CONTEXT OF SITUATION									
Yes	N	2	1	1	-	1	-	-	1
	%	(2)	(4)	(2)	-	(1)	-	-	(3)
No	N	133	25	57	51	74	14	28	32
	%	(98)	(96)	(98)	(100)	(99)	(100)	(100)	(97)
Base		135	26	58	51	75	14	28	33

Only three parents offered responses that in any way considered the emotional needs of the child or the context of the situation. This small number seems to support the idea that parents will make every effort to termination this type of behavior. In essence, parents are saying that there are no circumstances that make such behavior permissible.

In terms of age appropriate responses, the porportion of parents who take age into account is also small: 10% of all respondents. Several mothers recognized that sharing behavior can only be encouraged past infancy. For instance: "at a certain age a child doesn't know how to share. There isn't much you can do until a child is old enough." This particular mother went on to explain that while she would try to teach her older child the importance of sharing, she would have to suffice with distracting the youngest.

1.8 Aggression toward others

"Supposing your child hits another child, what do you do?"

This item presented a situation familiar to all parents. However, in the course of offering solutions, many parents reversed the siutation. That is, they responded in terms of their child being hit by another child. For the most part, such responses were offered to explain that the choice of solution varied with the type of aggression.

Eight coding categories were developed for this item:

- INVESTIGATION

  Inquiry into the underlying reason.

- EXPLANATION

  Hitting is wrong, if child hits others they will hit him.

- VERBAL DISAPPROVAL

- HUMILIATION

  Shaming the child, demanding apologies.

- RETALIATION

  Child gets "paid back" because the other child hits him.

- ISOLATION

  Removal of child.

- IGNORING

- PHYSICAL PUNISHMENT

1.8.1 The number of solutions

Table IV-6a. Aggression toward others; distribution of the number of solutions - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	32	9	11	12	11	3	1	7
	%	(24)	(35)	(19)	(24)	(8)	(12)	(2)	(14)
Two responses	N	66	7	36	23	79	14	37	28
	%	(49)	(27)	(62)	(45)	(59)	(54)	(64)	(55)
Three responses	N	31	9	8	14	42	8	19	15
	%	(23)	(35)	(14)	(27)	(31)	(31)	(33)	(29)
Four responses	N	6	1	3	2	3	1	1	1
	%	(4)	(4)	(5)	(4)	(2)	(4)	(2)	(2)
Mean		2.08	2.08	2.05	2.12	2.27	2.27	2.34	2.20
S.D.			.91	.73	.81		.71	.54	.69
Base: number of respondents		135	26	58	51	135	26	58	51

$t_{2-5} = -2.42$; $P < .01$

Table IV-6b. Aggression toward others; distribution of the number of solutions - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	(1) NEW	(2) SHORT	(3) LONG	TOTAL	(4) NEW	(5) SHORT	(6) LONG
One response	N	12	4	6	2	13	2	5	6
	%	(16)	(29)	(21)	(6)	(17)	(14)	(18)	(18)
Two responses	N	33	5	9	19	36	7	12	17
	%	(44)	(36)	(32)	(58)	(48)	(50)	(43)	(52)
Three responses	N	25	5	12	8	24	5	11	8
	%	(33)	(36)	(43)	(24)	(32)	(36)	(39)	(24)
Four responses	N	5	-	1	4	2	-	-	2
	%	(7)	-	(4)	(12)	(3)	-	-	(6)
Mean		2.31	2.07	2.28	2.42	2.20	2.21	2.21	2.18
S.D.			.80	.84	.78		.67	.72	.80
Base: number of respondents		75	14	28	33	75	14	28	33

With the exception of long and short-time rural parents, the number of responses generated by each subgroup increased from T1 to T2. The number of solutions generated by short-time urban participants increased significantly in T2. In addition, whereas at T1, 66% of the new urban and 72% of the new rural members offered two or more responses, at T2 these percentages were 89% and 86% respectively.

1.8.2 Types of solutions: first response

Table IV-6c. Aggression toward others; distribution of first responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	16	4	3	9	32	7	10	15
	%	(12)	(15)	(5)	(18)	(24)	(27)	(17)	(29)
Explanation	N	29	6	14	9	34	6	19	9
	%	(21)	(23)	(24)	(18)	(25)	(23)	(33)	(18)
Verbal disapproval	N	23	5	11	7	12	3	8	1
	%	(17)	(19)	(19)	(14)	(9)	(12)	(14)	(2)
Humiliation	N	3	-	1	2	2	1	1	-
	%	(2)	-	(2)	(4)	(2)	(4)	(2)	-
Retaliation	N	16	2	7	7	18	2	8	8
	%	(12)	(8)	(12)	(14)	(13)	(8)	(14)	(16)
Isolation	N	7	3	3	1	7	2	3	2
	%	(5)	(12)	(5)	(2)	(5)	(8)	(5)	(4)
Ignore	N	3	1	-	2	7	1	-	6
	%	(2)	(4)	-	(4)	(5)	(4)	-	(12)
Physical punishment	N	38	5	19	14	22	4	9	9
	%	(28)	(19)	(33)	(27)	(16)	(15)	(16)	(18)
Other	N	-	-	-	-	1	-	-	1
	%	-	-	-	-	(1)	-	-	(2)
Base		135	26	58	51	135	26	58	51

Table IV-6d. Aggression toward others; distribution of first responses - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	6	-	2	4	13	1	7	5
	%	(8)	-	(7)	(12)	(17)	(7)	(25)	(15)
Explanation	N	12	-	5	7	24	6	8	10
	%	(16)	-	(18)	(21)	(32)	(43)	(28)	(30)
Verbal disapproval	N	15	5	7	3	7	1	4	2
	%	(20)	(36)	(25)	(9)	(9)	(7)	(14)	(6)
Humiliation	N	2	-	2	-	1	-	-	1
	%	(3)	-	(7)	-	(1)	-	-	(3)
Retaliation	N	6	2	1	3	13	3	6	4
	%	(8)	(14)	(4)	(9)	(17)	(21)	(21)	(12)
Isolation	N	8	-	3	5	5	-	2	3
	%	(11)	-	(11)	(15)	(7)	-	(7)	(9)
Ignore	N	3	-	1	2	3	-	1	2
	%	(4)	-	(4)	(6)	(4)	-	(4)	(6)
Physical punishment	N	23	7	7	9	9	3	-	6
	%	(31)	(50)	(25)	(27)	(12)	(21)	-	(18)
Other	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Base		75	14	28	33	75	14	28	33

In terms of the chi-square analyses performed on these data, comparisons were made between responses coded investigation, explanation and verbal disapproval and those coded humiliation, retaliation, isolation, ignoring the situation and physical punishment. Decisions to collapse the categories into the above sets were based again on the adaptiveness of the approach; the first set of responses was judged to be more adaptive than the second. Using these sets, a significant difference was found between high and low involved rural subjects at T1: highly involved subjects were most likely to choose more adaptive approaches as first solutions to the situation. No significant differences occurred either within subsamples or across time.

At T1, physical punishment was the response mentioned by more people than any other solution. This was particularly true for new rural members among whom 50% chose this as their first technique for handling the situation. New urban parents, on the other hand, were less likely than any other group to use physical punishment (19%).

At T2, the proportion of parents choosing physical punishment as a first response decreased markedly. At this time, explanation was the most frequently mentioned technique followed by investigative behavior. In addition, the number of persons reporting verbal disapproval, i.e., saying "no, don't do that" without further explanation, at T2 was half that at T1. Overall, but particularly among new rural parents, the shift in response pattern was in the expected direction.

1.8.3 Types of solutions: all responses

Table IV-6e. Aggression toward others; distribution of all responses - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	23	5	5	13	38	8	12	18
	%	(8)	(9)	(4)	(12)	(12)	(14)	(9)	(16)
Explanation	N	53	10	24	19	73	12	34	27
	%	(19)	(19)	(20)	(18)	(24)	(20)	(25)	(24)
Verbal disapproval	N	39	7	18	14	30	9	14	7
	%	(14)	(13)	(15)	(13)	(10)	(15)	(10)	(6)
Humiliation	N	14	1	6	7	11	3	4	4
	%	(5)	(2)	(5)	(6)	(4)	(5)	(3)	(4)
Retaliation	N	31	5	13	13	38	6	21	11
	%	(11)	(9)	(11)	(12)	(12)	(10)	(15)	(10)
Isolation	N	37	11	15	11	34	8	14	12
	%	(13)	(20)	(13)	(10)	(11)	(14)	(10)	(11)
Ignore	N	7	2	2	3	12	2	1	9
	%	(2)	(4)	(2)	(3)	(4)	(3)	(1)	(8)
Physical punishment	N	77	13	36	28	69	11	36	22
	%	(27)	(24)	(30)	(26)	(22)	(19)	(26)	(20)
Other	N	-	-	-	-	2	-	-	2
	%	-	-	-	-	(1)	-	-	(2)
Base: total responses		281	54	119	108	307	59	136	112

Table IV-6f. Aggression toward others; distribution of all responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Investigation	N	7	-	3	4	19	3	7	9
	%	(4)	-	(5)	(5)	(12)	(10)	(11)	(13)
Explanation	N	21	1	7	13	38	7	14	17
	%	(12)	(3)	(11)	(16)	(23)	(23)	(23)	(24)
Verbal disapproval	N	31	9	11	11	20	3	8	9
	%	(18)	(31)	(17)	(14)	(12)	(10)	(13)	(13)
Humiliation	N	7	-	4	3	6	2	2	2
	%	(4)	-	(6)	(4)	(4)	(6)	(3)	(3)
Retaliation	N	13	2	4	7	22	5	10	7
	%	(8)	(7)	(6)	(9)	(13)	(16)	(16)	(10)
Isolation	N	41	5	15	21	32	3	11	18
	%	(24)	(17)	(23)	(26)	(19)	(10)	(18)	(25)
Ignore	N	5	-	3	2	3	-	1	2
	%	(3)	-	(5)	(3)	(2)	-	(2)	(3)
Physical punishment	N	43	11	16	16	23	8	7	8
	%	(25)	(38)	(25)	(20)	(14)	(26)	(11)	(11)
Other	N	5	1	1	3	2	-	2	-
	%	(3)	(3)	(2)	(4)	(1)	-	(3)	-
Base: total responses		173	29	64	80	165	31	62	72

The chi-square analyses on these data maintained the same response category sets as those for first response with one exception: responses coded isolation were excluded from the analyses. It was felt that isolation became a somewhat neutral approach to the situation when preceded by other solutions. Using these categories, no significant differences were produced by either the involvement or longevity data.

Among urban parents, when all options are taken together, physical punishment is the second most popular response, preceded by explanation: "First I'd explain that you shouldn't hit. If that didn't work it would be time for me to get me a switch. I can't stand no hard-headed kids. I teach the children to love and that other children is friends of his."

In the rural sample, explanation is the most frequently mentioned method, followed by isolation and then physical punishment. While new rural parents are somewhat more likely to use physical punishment than are ongoing rural parents, with few exceptions, the differences across longevity in both subsamples at T2 are not very great nor particularly consistent.

With some of the previous items, mothers would say that they never come up against the situation or they might offer one or two methods and then say, "I'm not sure what I'd do if that didn't work." Such was not the case with this particular item. In most instances, the mother was very certain of how she would deal with her child's aggressive behavior and when all else failed she felt she could more readily use physical punishment as a solution than might be true in other situations. Here, hitting the child or having the child hit was giving him "some of his own medicine." The following are illustrative of the types of responses received:

> "First I'd hit my child. If it kept happening, I'd have to whip some more. You can't get out of whipping a child."

"First I go over to see if the child is hurt. If he's not, I tell him to hit my child back. That way he won't be so free-handed."

"I separate the children and tell them that when they quiet down, then they can play."

"First I explain and then I cuddle the other child."

"I've got to find out the reason why. If my child has started it, he'll get it!"

"I never tell him to hit another child back the way some people do."

"Tell her the Lord won't bless you if you fight."

Several parents were concerned about the possibility of their children not being able to defend themselves in situations in which they were aggressed against. Responses of this nature were along the following lines:

"Mine gets hit all the time and she never hits back. She is now beginning to hit back and I don't stop her."

"I tell my children not to fight, but if somebody hits them they should hit back."

"I ignore the fight if it's someone in the street. They got to know how to fight in the street."

1.8.4 Age or context-relevant responses: Time 2

Table IV-6g. Aggression toward others; age appropriate response - understands emotional needs of child/context of situation.

RESPONSES		URBAN				RURAL			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
AGE APPROPRIATE RESPONSE									
Yes	N	11	2	5	4	7	-	4	3
	%	(8)	(8)	(9)	(8)	(9)	-	(14)	(9)
No	N	124	24	53	47	68	14	24	30
	%	(92)	(92)	(91)	(92)	(91)	(100)	(86)	(91)
UNDERSTANDS EMOTIONAL NEEDS OF CHILD/CONTEXT OF SITUATION									
Yes	N	9	3	3	3	7	2	1	4
	%	(7)	(12)	(5)	(6)	(9)	(14)	(4)	(12)
No	N	126	23	55	48	68	12	27	29
	%	(93)	(88)	(95)	(94)	(91)	(86)	(96)	(88)
Base		135	26	58	51	75	14	28	33

As was the case with all other items, the proportion of parents considering age or context was relatively small: 9% and 8% respectively. For many, the context of the situation became either a question of who hit whom or else the need for the child to defend himself as discussed above: "If it were my child who hit, I'd punish or spank him. If it was the other child, I'd speak to his mother. In any case, it depends on why they're fighting."

In terms of age considerations, more often than not the response was similar to the following: "If the child is the same age I would tell the other child to hit him back. If the other child was younger than my own, I would spank my child." The question was more one of who should hit the child rather than whether or not the child should be hit.

1.9 Summary of solutions to situations

The following represents a summary of findings for each of the measures used.

Number of alternatives

There is no evidence to support the prediction that PCC will have an impact on the number of options or alternatives available to parents in a child-centered problem situation. New urban parents gave significantly more alternatives in T2 than in T1 for one of the six situations. Short-time urban parents gave significantly more alternatives for three of the six situations in T2 than in T1. Long-term rural parents gave significantly more alternatives over time for two of the six situations.

Most subgroups show no significant changes over time in the majority of situations. Moreover, there are no clearly discernible trends in the data. In some instances new parents offer more alternatives than do ongoing parents, and in some instances the trend is in the direction of a decrease in the number of alternatives given by any subgroup over time.

There are no consistent differences between high and low involved parents in terms of the number of options available.

First response

In three of the six problem situations, the first response of parents became less punitive and more adaptive over time.

Parents whose first solution in their response repertoire was a punitive one, became less likely to offer such a solution as a first choice over time. Parents were more likely to think first of a supportive, educative, and reasoned response than an angry one to child-centered problems.

High involved urban parents were more likely to think of adaptive first solutions than low involved parents in two situations. Rural high involved parents were more likely to offer adaptive first solutions than low involved parents in one situation.

Overall, the data support the hypothesis that PCC has an impact on the quality of the response available to parents in a child problem situation. As a result of the PCC experience parents tend to be less likely to hit, deride, or isolate young children who are being difficult. The data are supportive of the hypothesis but are not conclusive. A substantial proportion of PCC parents react punitively as a first option to almost any situation in which a child is not behaving in an exemplary manner.

Overall response patterns

While parents are more likely to give an adaptive than a punitive response as a first alternative, changes over time are less impressive when it comes to the full complement of parental responses. Parents are less likely to be punitive as a first response, but following the first one or two responses there are few changes over time in terms of punitiveness. If the first and second options don't work, between 1 and 30% of PCC parents, depending on the situation, are likely to respond in a punitive manner. It seems that as a result of PCC, punitive responses are lower on the response hierarchy but are certainly not extinguished.

Age and context-relevant responses

It was hypothesized that as one outcome of PCC, parents would be more sensitive to the underlying nuances of children's behavior. Responses which are adaptive for use with one age group are less adaptive or even inappropriate for use with another age group. Similarly, the underlying meaning of a child's behavior can dictate a differential response from the parent. Sound parenting implies the ability to respond differentially to the cues of a given child in a given situation.

In all of the situations presented, approximately 10% of the parents were sensitive to the age of the child and approximately 6% of the parents took into account the underlying emotional state of the child in selecting their responses to the child. Based on these data, it cannot be said the PCC makes parents more likely to take into account the age or the needs of the child in thinking through what should be done in a given situation.

2.0 Basic issues and feelings involved in child rearing

2.1 Toilet training

Subjects were asked to tell at what age they would begin toilet training and how they would go about doing the training. At T2 six codes were developed for methods of training:

- MODELING

  Baby watches others in family

- REGULARITY

  Child is taken to bathroom at regular intervals.

- POSITIVE REINFORCEMENT

  Correct behavior is rewarded, mistakes are ignored.

- NEGATIVE REINFORCEMENT

  Punishment for mistakes.

- POSITIVE AND NEGATIVE REINFORCEMENT

  Reward correct behavior; punish mistakes

- LAISSEZ-FAIRE

  No method used: child learns when he is ready.

As these codes were not used for data collected at T1, only T2 data are presented. The base numbers in Table IV-7c correspond to the number of responses given. Although parents were not requested to give more than one response, all methods mentioned were coded.

2.1.1 Age at which toilet training is begun

Table IV-7a. Age of toilet training - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
10 months or less	N	31	10	15	6	27	5	13	9
	%	(23)	(38)	(26)	(12)	(20)	(19)	(22)	(18)
11-14 months	N	51	4	24	23	54	6	27	21
	%	(38)	(15)	(41)	(45)	(40)	(23)	(46)	(41)
15-22 months	N	22	4	7	11	29	9	6	14
	%	(16)	(15)	(12)	(22)	(21)	(35)	(10)	(27)
23-26 months	N	11	3	4	4	13	1	9	3
	%	(8)	(12)	(7)	(8)	(10)	(4)	(16)	(6)
27 months or more	N	1	-	1	-	1	-	-	1
	%	(1)	-	(2)	-	(1)	-	-	(2)
When child first walks	N	7	2	2	3	8	3	2	3
	%	(5)	(8)	(3)	(6)	(6)	(12)	(3)	(6)
No age mentioned	N	12	3	5	4	3	2	1	-
	%	(9)	(12)	(9)	(8)	(2)	(8)	(2)	-
Base		135	26	58	51	135	26	58	51

Table IV-7b. Age of toilet training - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
10 months or less	N	6	1	1	4	-	-	-	-
	%	(8)	(7)	(4)	(12)	-	-	-	-
11-14 months	N	11	2	4	5	13	2	4	7
	%	(15)	(14)	(14)	(15)	(17)	(14)	(14)	(21)
15-22 months	N	31	6	12	13	32	8	11	13
	%	(41)	(43)	(43)	(39)	(43)	(57)	(39)	(39)
23-26 months	N	16	4	6	6	13	1	6	6
	%	(21)	(29)	(21)	(18)	(17)	(7)	(21)	(18)
27 months or over	N	1	-	-	1	2	-	1	1
	%	(1)	-	-	(3)	(3)	-	(4)	(3)
When child first walks	N	2	1	-	1	6	2	1	3
	%	(3)	(7)	-	(3)	(8)	(14)	(4)	(9)
No age mentioned	N	8	-	5	3	9	1	5	3
	%	(11)	-	(18)	(9)	(12)	(7)	(18)	(9)
Base		75	14	28	33	75	14	28	33

Urban parents tend to begin toilet training their children at a much earlier age than is true of rural parents. From the data it can be seen that 60% of the urban mothers begin training when the child is 14 months or younger whereas only 17% of the rural members begin at this age. In fact, not one rural parent reported teaching the child to use the toilet at 10 months or less as did 20% of the urban respondents. Some mothers who begin training at this early age replied:

> "I start even before 9 months. I have noticed their pattern, and you will if you're observant, and so I try to get them to the pot at the appropriate time."

> "I start at 8 months. I put them on the potty chair and give them breakfast there."

> "You start when they're first born. My mama has had the baby on the pot since she came from the hospital."

The majority of rural parents begin training between 15 and 26 months; among urban respondents the modal range is 11 to 14 months. In both samples, new and ongoing members favor the same time periods.

A small proportion of mothers said they could not state a particular age, because the age would be dependent on the child's readiness.

The following are illustrative of the types of responses offered:

> "I usually start when the child can hold a cup. Each child develops differently. Forcing a child makes matters worse. They will make some kind of motion when they are ready."

> "I start training my children with precise care when they first start to walk. I insist that I won't be changing pants all the time."

> "In their own way, each child lets you know when he's ready for training."

2.1.2 Methods of toilet training

Table lv-7c. Toilet training - method used; distribution of all responses.

		TOTAL URBAN/RURAL				URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Baby watches others in family	N %	64 (22)	10 (18)	24 (20)	30 (25)	34 (18)	4 (12)	13 (16)	17 (23)	30 (28)	6 (26)	11 (28)	13 (28)
Take baby to bathroom at regular intervals	N %	163 (55)	33 (54)	72 (60)	58 (49)	114 (61)	23 (70)	51 (64)	40 (55)	49 (45)	10 (43)	21 (52)	18 (39)
Praise, reward correct behavior & ignore mistakes	N %	24 (8)	5 (9)	6 (5)	13 (11)	10 (5)	2 (6)	4 (5)	4 (5)	14 (13)	3 (13)	2 (5)	9 (20)
Punish for mistakes	N %	16 (5)	3 (5)	4 (3)	9 (8)	11 (6)	1 (3)	2 (2)	8 (11)	5 (4)	2 (9)	2 (5)	1 (2)
Reward correct behavior and punish for mistakes	N %	10 (3)	1 (2)	6 (5)	3 (3)	7 (4)	1 (3)	4 (5)	2 (3)	3 (3)	- -	2 (5)	1 (2)
No method used child learns when ready	N %	18 (6)	4 (7)	8 (7)	6 (5)	10 (5)	2 (6)	6 (8)	2 (3)	8 (7)	2 (9)	2 (5)	4 (9)
Base: total responses		295	56	120	119	186	33	80	73	109	23	40	46

Chi-square analyses were performed in order to determine if significant differences in methods of training existed either within subsamples over time or as a function of a participant's level of involvement in PCC. None of the comparisons proved significant.

Among urban respondents, the majority of parents report that they train their children by taking them to the bathroom at regular intervals. Said one mother by way of explanation: "In the morning, when the child wakes up, put him on the pot to urinate because that's what you teach first." This technique was most favored by new parents, although the percentages for ongoing members are high. Having the baby watch other family members, either siblings or parents, is the next most frequently mentioned response.

Among rural parents, these two methods are also the most popular, although fewer parents train through the regular interval method and more through observing than is true of urban parents. It is interesting to note that 20% of the rural long-time parents report that they would praise correct behavior and ignore mistakes. This percentage is relatively high when compared to those for new and short-time parents (13% and 5% respectively).

Most parents reported that they would either take the child to the bathroom at regular intervals or allow him to watch other family members. The following serve as examples:

> "I put him on the pot for about 45 minutes. If he goes he can leave, if not he has to stay there."

This rather long period of time in the bathroom is quite different from the method used by another mother:

> "I take him to the bathroom very often, but I don't leave him on the potty too long -- not over two minutes sitting there."

Some mothers had a more casual laissez-faire approach:

> "I don't want to force my child because that's no good so I just show him the potty and tell him what to do and he does it when he's ready."

> "I never really taught my child. He had a soup can that he carried around and used. He thought it was fun."

Other mothers resorted to physical punishment as a means of training. One parent who said that she began training between 11 and 14 months said:

> "When she does it in her pants I'll spank her and then take her to the rest rooms and make her sit there."

Another parent who was particularly frustrated by her child's slow progress related the following:

> "My son wouldn't be potty trained. He would sit on the potty, scream and not go. The doctor told me not to worry until he was three. Two months before he was three I took a cane switch and every time he wet his pants I gave him a swat. He's now trained."

2.2 The pleasures of parenthood

"Mothers differ a great deal in what they enjoy doing most with their children. What do you enjoy doing most with your children?"

Six coding categories were developed:

- LEARNING/TEACHING
  Mother indicates her pleasure in helping the child to learn or her pride in what he is able to learn and do.
- COMPANIONSHIP
  Mother indicates she likes to play, spend time, talk, go places with, take care of child.
- GROWTH PROCESS
  Mother likes to "see him grow," observe change.
- MATERIAL PROVISION
  Mother enjoys buying things, e.g., food, toys.
- GETTING COMPLIMENTS
  Mother likes admiration she gets from others as a function of the child's performance.
- GOOD BEHAVIOR
  Mother enjoys that the child is good, not too demanding, is able to manage on his own.

2.2.1 Distribution of responses

Table IV-8a. What mothers like about children; distribution of all responses - urban.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Learning/ teaching	N %	99 (38)	18 (37)	47 (41)	34 (35)	66 (26)	12 (26)	32 (27)	22 (26)
Companionship	N %	83 (32)	20 (41)	32 (28)	31 (32)	127 (51)	25 (53)	56 (47)	46 (54)
Growth process	N %	18 (7)	4 (8)	7 (6)	7 (7)	16 (6)	3 (6)	9 (8)	4 (5)
Material provision	N %	33 (13)	4 (8)	20 (17)	9 (9)	12 (5)	1 (2)	8 (7)	3 (4)
Getting compliments	N %	9 (3)	2 (4)	1 (1)	6 (6)	7 (3)	4 (9)	3 (3)	- -
Cooperation/ good behavior	N %	20 (7)	1 (2)	9 (8)	10 (10)	6 (2)	- -	3 (3)	3 (4)
Other	N %	- -	- -	- -	- -	16 (6)	2 (4)	7 (6)	7 (8)
Base: total response		262	49	116	97	250	47	118	85

Table IV-8b. What mothers like about children; distribution of all responses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Learning/ teaching	N	59	10	21	28	26	5	8	13
	%	(43)	(38)	(44)	(45)	(21)	(23)	(16)	(24)
Companionship	N	53	12	17	24	68	12	25	31
	%	(39)	(46)	(35)	(39)	(54)	(55)	(51)	(56)
Growth process	N	9	1	4	4	13	3	5	5
	%	(7)	(4)	(8)	(6)	(10)	(14)	(10)	(9)
Material provision	N	9	2	4	3	5	-	4	1
	%	(7)	(8)	(8)	(5)	(4)	-	(8)	(2)
Getting compliments	N	-	-	-	-	1	1	-	-
	%	-	-	-	-	(1)	(5)	-	-
Cooperation/ good behavior	N	6	1	2	3	6	1	2	3
	%	(4)	(4)	(4)	(5)	(5)	(5)	(4)	(5)
Other	N	-	-	-	-	7	-	5	2
	%	-	-	-	-	(6)	-	(10)	(4)
Base: total responses		136	26	48	62	126	22	49	55

Although chi-square analyses showed no significant differences between subgroups, the most frequently mentioned category among all parents was companionship. Parents indicated that they enjoyed participating in outdoor activities with their children such as picnics, ball games, hikes, swimming. The proportion of parents offering this response increased markedly from T1 to T2. This increase may in part be a function of the time of year at which the interview was done. T1 interviews were conducted during the fall when parents had the winter months to look forward to, months that are particular difficult in rural areas. In contrast, T2 interviews were done during the spring when the prospect of warm weather and the coming school vacation was foremost in people's minds.

Approximately one-quarter of the responses from urban parents and one-fifth of those from rural subjects were related to teaching and learning. Several mothers reported that they enjoyed watching and participating in the child's learning process a good deal more as a result of PCC membership.

The remaining 25% of the responses were distributed over the other categories. For the most part, the changes in response frequency from T1 to T2 were minimal. Within the urban subsample, the exceptions are that fewer parents mention material provision, receipt of compliments or cooperation in T2 than was true in T1.

The following are illustrative of the types of responses received:

> "All of my children are very intellectual and are interested in learning and I love to see them learn and achieve."

> "I love to read stories to them. They get so excited about them, but so do I. Children like to hear the same story over and over again, and there are some that even though I've read them so many times I still think they're funny. That must be the child in me."

> "I just enjoy being with them. We make every minute count. We make simple things into a lesson like counting steps and naming things. It's fun for all of us and the children are learning something."

> "I love to watch my children play because they do the damn cutest things."

One mother who indicated that she enjoyed spending time with her children added the following:

> "I may be very neglecting. I roughhouse them; any other playing they do, they do by themselves. I'll be honest, I don't enjoy playing with dolls and trucks. I'm a grown-up -- why should I get down on the floor and act like a nut -- I'm not a child. They don't do what I do, why should I do what they do?"

2.3 Change in feelings as a result of PCC

Parents were asked, "Have your feelings about your children, or about being a mother, changed since joining the PCC? If so, how?" Many parents used this opportunity to express their feelings about the program, about changes within themselves not related to parenting or motherhood, and about gains made by their children. This was an open-ended question for which codes were not developed. Rather, responses were read and sorted so that representative samples of the variety of comments offered could be presented.

The following comments are related, more or less, to parents' feelings about the teaching and learning process as it is implemented at the Centers:

> "Before I put my daughter in the Center I thought that everyone over there was crazy. And then, there I was and I became involved and I saw so many things. They can teach your children coordination and developmental games. It's not just a place to go and pass the time, you can learn a lot."

> "They showed me that it's important to teach your children before school so that they can get ready for school. The ones that have been to PCC have been doing better in school."

> "They have taught sewing and home management and I took a child development class. They really teach parents and children to make out in the world and improve their skills."

> "Without PCC they (the children) wouldn't be as advanced as they are. They're more advanced than other children their ages."

> "My children used to get on my nerves because they were bored. I can now keep them busy constructively. I've learned a lot about technique, how to use toys appropriately, not just throw them down."

A large proportion of the responses received did deal with changes in attitudes about being a mother, in addition to changes in parents' understanding of their children or the need for certain types of parenting behaviors. The following responses, varied in the areas upon which they touch, should serve to illustrate some of the changes that did occur:

> "At first I used to get so bored when it came to doing things for the children, like reading to them. I came here and took a child development course. At first I thought it was all a lot of jazz, but I finally decided to just try -- and it works! I really love doing things with the children."

> "When I had the first baby I thought that the only thing a mother had to do was feed a baby and keep it clean. I learned so much about young children from PCC; about things you can teach your children even before they're a year old. PCC helped me understand that children have feelings too and need love and attention."

> "I used to think my children were mean. Now I know that all children have tantrums."

> "Before I was very nervous and I took it out on the children. Since PCC, I can talk with the children and I understand them better."

> "PCC has shown me that children are human beings with real feelings and that they understand a lot more than we give them credit for."

> "I learned alternatives to beating the daylights out of the children and being aware of my children's needs and how to take care of them. I learned that children develop and go through different things at different ages."

For many, membership in the PCC has provided them with the opportunity to meet other adults, to meet people with similar concerns and needs and to build a social network for themselves that heretofore did not exist. For some, the PCC environment has helped to instill feelings of social confidence and has encouraged more open behavior and relationships:

> "It has made me see that a lot of the opinions I've had were true, but it has also taken away a lot of my fears. Especially when we meet with the other parents, I see that a lot of people have the same problems and there are a lot of ways to handle things. For the children? They're here with children of their own age and they learn how to relate to other children."

> "It's made a difference in relation to the community. It's provided a place where the children see parents coming together and planning."

> "I'm not as shy as I used to be because through the PCC I got out more and spent time with people and had a chance to get over my shyness. By talking with a lot

of different people at the PCC I just learned new ideas about taking care of children and about getting along with people."

"Before PCC I was stuck out in the country sticks and I felt stuck and resentful. With PCC, it was some place to go and it gave me a feeling and purpose for myself. I felt better about myself. It improved my outlook on life and it improved my attitude toward my children and the way I got along with them."

"It's made me feel different about living here; it's made me get acquainted with people. Get with a group and get talking -- you'd be surprised what us old hens talk about. You'd be surprised how many mothers got the same darn problem you've got and you thought you were the onliest one."

Not all of the comments received were positive. While the majority of the parents expressed feelings of gain as a result of PCC membership, some respondents did not feel that the program was making an appreciable difference in their or their families' lives:

"We've met many different people, all good people, but I don't think they have really helped us to improve too much. For our kids - there's very, very little benefits for them. The baby gets the most benefit - for her to be better prepared for going to Head Start."

"The program helps the children to learn to do things, read and play games. But it hasn't taught me anything so there hasn't been a change with me."

"I feel I'm ignoring the children when I'm at the Center."

"It hasn't made a difference because I was doing the same things before I joined."

"The program is really good for mothers who don't know any better. I was underincome, but I wasn't underprivileged and neither were my kids. They always had good food and a lot of love and a mother who could take care of them."

2.4 Summary of basic issues and feelings

There are no changes over time in terms of either the age at which parents begin toilet training or the methods which they use to achieve such training. The majority of urban parents toilet train their children at a younger age (before 14 months) than do rural parents (15-26 months). The majority of all parents toilet train their children by taking them to the bathroom at regular intervals and/or having them ovserve other family members.

There are no changes over time in terms of what parents report enjoying most about their children. The largest proportion of parents mention companionship as the most pleasurable aspect of having children. Approximately 22% of all parents mention teaching and watching the children learn as a pleasurable aspect of having children.

3.0 Parenting attitudes, behavior, and feelings

Eleven Likert items were designed to measure parental attitudes, behavior, and feelings. Six of these items ask mothers to identify whether they feel or act in a particular way "most of the time or always," "a good deal of the time," "about half the time," "occasionally," or "seldom or never:"

- "I feel I am a good mother."
- "I worry about whether I am doing right for my children."
- "The children are just too much for me to handle."*
- "I hold my baby when giving him his milk."
- "I keep my baby in his crib; that way he won't get into trouble."*
- "I talk to my baby while he is eating."

The remaining five items are scaled along dimensions of "strongly agree" to "strongly disagree:"

- "As long as you take basic care of your baby, i.e., feed and clean him, he should turn out just fine."*
- "Most babies of a particular age are pretty much alike."*
- "Babies can't learn much before the age of one."*

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* Items with an asterisk (*) are ones for which agreement has a negative connotation. In order that all items may be compared, the scales for these items have been reversed: means have been stated as being the same distance from the scale's midpoint (3.00) but on the other side of that midpoint (i.e., 2.51 would become 3.49). Thus, in all instances, the higher the mean the more "positive" the response.

- "Babies of about a year and a half aren't interested in books. They just tear them."*
- "Being a good mother is a really important job."*

Means and standard deviations on these data are presented below and significant t-tests are reported. All t-tests are based on one-tailed analyses.

3.1 Feelings of adequacy as a parent

Table IV-9a. Means and standard deviations on items related to feelings of adequacy as a parent - urban.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "I feel I'm a good mother."	M	4.15	4.65	4.23	4.11	4.50	4.37
	SD	1.20	.66	.94	1.15	.95	.95
2. "I worry about whether I'm doing right for my children "	M	3.46	3.91	3.59	3.73	3.83	3.82
	SD	1.45	1.32	1.43	1.35	1.27	1.38
3. "The children are just too much for me to handle."	M	4.39	4.12	4.02	4.27	4.17	3.98
	SD	.92	1.23	1.15	.86	1.12	1.06

Item 1: t1-2= -2.43; P=<.01
t2-3= 2.70; P=<.01

Table IV-9b. Means and standard deviations on items related to feelings of adequacy as a parent - rural.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "I feel I'm a good mother."	M	4.07	4.21	4.33	4.36	4.29	4.18
	SD	1.16	.86	.84	.81	.84	.72
2. "I worry about whether I'm doing right for my children."	M	3.79	3.64	3.94	3.86	3.29	3.88
	SD	1.42	1.37	1.23	1.41	1.41	1.15
3. "The children are just too much for me to handle."	M	4.71	4.14	3.88	4.37	4.00	3.88
	SD	.45	.69	.84	.61	.76	1.12

Item 2: t5-6= -1.78; P=<.05

Item 3: t1-4=1.70; P=<.05
t1-2=2.74; P=<.01
t1-3=3.42; P=<.01

3.1.1 "I feel I am a good mother."

The vast majority of urban (86% at T2) and rural (84% at T2) mothers feel that they are good at their parenting job either all of the time or a good deal of the time.

Among urban respondents at T1, a significantly higher proportion of short-time parents felt they were good mothers more often than did either new or long-time parents. This difference is not maintained at T2 nor are there any differences among rural parents. Similarly, there are no significant differences between high and low involved parents.

3.1.2 "I worry about whether I'm doing right for my children."

For these data, the only significant difference is between short and long-time rural respondents at T2. At this time, long-time parents are found to show concern a greater proportion of the time than are short-time parents. While this is the only difference that proved statistically significant, some interesting trends are apparent. At T1, 69% of the urban and 60% of the rural respondents reported concern a good deal of the time or always. The proportion of new parents who stated that they were concerned a good deal of the time or always, increased somewhat in T2 (urban: 46% at T1, 69% at T2; rural: 64% at T1, 71% at T2). This trend may be a function of an increased awareness of the complexities of parenting, which may accompany participation in PCC.

At T2, a substantial group (22%) claim not to worry or to worry rarely. In this category, approximately 27% of the new parents answered similarly compared to only 17% of the long-time parents. This slight increase in concern across longevity supports the notion that understanding of the complexities of parenthood can lead parents to a more self-critical and demanding appraisal of their performance as parents.

3.1.3 "The children are just too much for me to handle."

The majority of parents (approximately 80% at both T1 and T2) state that the children are never or only occasionally too much for them to handle. Among new rural parents at T1, none (0%) felt that the children were too much to handle more than occasionally.

At T2, significantly more new rural parents state that they find the children difficult to manage at least half of the time. The rural response pattern at T1 produced significant differences between new and short-time parents and between new and long-time parents. The pattern is such that new rural parents report that coping with the children is a problem the least amount of time, short-time members report this to be a problem more often, and long-time members state that they find the children are too much to handle more often than do the other two subgroups. These differences are not significant, but are in the same direction, at T2. Inspection of the data shows that this trend is consistent, although not significant, among urban parents as well at both T1 and T2. Such a pattern does not necessarily mean that ongoing parents are less able to cope with their children than are new parents. Rather, this finding seems to support the idea that PCC participation increases the awareness of nuances of parenting and the performance demands parents make on themselves. In addition, PCC may help parents to be more open about episodic feelings of being helpless and overwhelmed.

The involvement data for this item show no significant differences between high and low involved parents at either interview time.

3.2 Parenting behavior

Parents were asked to identify their actual behavior on these items.

Table IV-10a. Means and standard deviations on items related to parenting behavior - urban.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "I hold my baby when giving him his milk."	M	3.15	3.72	3.53	2.65	3.41	3.86
	SD	1.68	1.56	1.61	1.66	1.62	1.52
2. "I keep my baby in his crib; that way he won't get into trouble."	M	4.23	3.66	3.90	3.77	3.93	3.80
	SD	1.34	1.55	1.33	1.53	1.31	1.48
3. "I talk to my baby while he is eating."	M	3.77	3.88	4.08	3.69	3.71	4.16
	SD	1.19	1.27	1.23	1.49	1.34	1.19

Item 1: t4-5= -1.95; P=<.05
t4-6= -3.15; P=<.01

Item 3: t5-6= -1.82; P=<.05

Table IV-10b. Means and standard deviations on items related to parenting behavior - rural.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "I hold my baby when giving him his milk."	M	4.29	4.11	4.24	3.79	3.75	4.03
	SD	.96	1.20	1.02	1.47	1.27	1.14
2. "I keep my baby in his crib; that way he won't get into trouble."	M	3.93	4.43	4.39	4.57	4.32	4.15
	SD	1.53	1.12	.98	1.05	1.04	1.18
3. "I talk to my baby while he is eating."	M	4.29	4.43	4.39	4.07	4.14	4.24
	SD	1.22	1.01	.98	1.33	.99	.95

3.2.1 "I hold my baby while giving him his milk."

At both T1 and T2, ongoing urban participants were more likely to hold their baby for at least half of his feedings than were new members. The differences in T2 between urban subgroups are significant for this item. New parents held their babies during feeding significantly less often than did either short or long-time members. Seventy-three percent of the long-time and 59% of the short-time urban members stated that they held their babies while giving them milk most, or a good deal of the time, whereas only 35% report this frequency among new participants.

Within the rural subsample, long-time parents also report holding their babies for the greatest number of feedings. However, within this subsample, the reported behavior of new and short-time members are virtually the same.

At T2, highly involved urban participants reported holding the baby during feeding a significantly greater proportion of time than did less involved parents. No other differences in terms of involvement proved significant.

3.2.2 "I keep my baby in his crib; that way he won't get into trouble."

From the earliest time of PCC, observers reported the tendency of mothers to keep babies in their cribs a great deal of the time. Anecdotal reports from PCC's have told of mothers who became convinced of the importance, in developmental terms, of allowing periods of free movement. Hence, this item is intended to provide some hard data substantiation for this reported PCC impact.

The vast majority of all parents (approximately 75% at both T1 and T2) report that they keep their babies in their cribs only occasionally or not at all. Among the small proportion of parents who state that the child is in his crib more than half of the time, the pattern of response does not support the prediction that this behavior would be least frequent among ongoing members. In fact, among urban respondents at T1, and rural respondents at T2, ongoing parents have a higher percentage (36% and 23% respectively) of respondents reporting that the child is in his crib more than half of the time than do new parents in these subsamples (28% and 7% respectively).

While the longevity data produced no significant differences, there is a significant difference between low and high involved urban parents at T1. Significantly more of the high involvement parents report that they never or only occasionally keep their babies in their cribs than is the case among low involved parents.

3.2.3 "I talk to my baby while he is eating."

The prediction is that long-time and highly involved mothers would be more likely to have absorbed two basic ideas of child development: it is important to vocalize and verbalize even with very young babies and eating is a very important activity which makes companionship desirable.

While several mothers mentioned during the interviews that they had begun taking meals with their children rather than feeding them separately, only one difference within subsamples proved significant: urban long-time members at T2 were significantly more likely to speak to their children during meals than were short-time members. At both T1 and T2 there was a slightly greater tendency for long-time participants to provide this type of companionship than was the case among new parents.

In general, rural parents are more likely to talk to their babies during mealtimes than are urban parents. At T2, 80% of the rural parents and 68% of the urban parents report that they engage in this activity at least a good deal of the time or more frequently. Twelve percent of the rural mothers (T2), but 23% of the urban respondents, report that they provide verbal mealtime companionship only occasionally.

The data for involvement are not supportive of the prediction that highly involved members would be most likely to talk to their babies while they are eating. Low and high involved participants of both subsamples at both interview times produced virtually the same response pattern: the vast majority reported engaging in this activity at least a good deal of the time.

3.3 Attitudes and knowledge of child development

The remaining five items ask mothers to express their agreement or disagreement with a particular statement.

Table IV-11a. Means and standard deviations on items related to attitudes and knowledge of child development - urban.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "As long as you take basic care of your baby, i.e., feed and clean him, he should turn out just fine."	M	3.27	3.28	3.29	3.27	3.24	3.20
	SD	1.26	1.30	1.32	1.29	1.33	1.36
2. "Most babies of a particular age are pretty much alike."	M	3.46	3.02	3.57	2.65	2.78	3.37
	SD	1.18	1.17	1.21	.96	1.13	1.22
3. "Babies can't learn much before the age of one."	M	4.12	3.91	3.84	4.27	3.86	3.90
	SD	1.01	.93	1.21	.65	1.06	1.12
4. "Babies of about a year and a half are not interested in books, they just tear them."	M	3.68	3.50	3.32	3.50	3.29	3.51
	SD	1.21	1.15	1.08	1.15	1.14	1.07
5. "Being a good mother is a really important job."	M	4.81	4.38	4.71	4.81	4.55	4.57
	SD	.39	.89	.50	.39	.83	.69

Item 2:
t1-4= 2.65; P=<.01
t2-3= -2.40; P=<.01
t4-6= -2.58; P=<.01
t5-6= -2.62; P=<.01

Item 3:
t4-5= 1.79; P=<.05

Item 5:
t1-2= 2.33; P=<.05
t2-3= -2.30; P=<.05

Table IV-11b. Means and standard deviations on items related to attitudes and knowledge of child development - rural.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "As long as you take basic care of your baby, i.e., feed and clean him, he should turn out just fine."	M	3.57	3.46	3.18	4.43	3.89	3.64
	SD	1.24	1.15	1.14	.90	1.29	1.23
2. "Most babies of a particular age are pretty much alike."	M	3.43	3.89	3.58	3.71	3.68	3.79
	SD	1.12	.98	1.08	1.33	1.14	.84
3. "Babies can't learn much before the age of one."	M	4.21	4.18	4.24	4.43	4.25	4.55
	SD	.86	.80	.85	.73	.78	.50
4. "Babies of about a year and a half are not interested in books, they just tear them."	M	3.57	3.86	3.70	4.00	3.75	3.82
	SD	.98	.95	.97	.76	1.12	1.06
5. "Being a good mother is a really important job."	M	4.29	4.25	4.36	4.36	4.46	4.70
	SD	1.03	.95	.77	1.04	.82	.76

Item 1:
t1-4= -2.02; P=<.05
t4-6= 2.13; P=<.05

Item 3:
t3-6= -1.73; P=<.05
t5-6= -1.75; P=<.05

Item 5:
t3-6= -1.74; P=<.05

3.3.1 "As long as you take basic care of your baby, for example, feed and clean him, he should turn out just fine."

This item is intended to measure whether PCC parents subscribe to the concept that good parenting means more than physical care.

Within the urban subsample, no changes over time occurred nor were there any differences of note between subgroups at either T1 or T2. In fact, the means for each subgroup are virtually the same.

There were, however, some interesting differences among rural respondents. The proportion of new parents who disagreed with the statement increased significantly from T1 to T2. At T2, significantly more new parents than long-time parents disagreed with the notion that basic care is all that is required for good parenting. Eighty-five percent of the new rural parents disagreed with the statement as compared to 66% of the long-time parents.

The longevity data do not support the prediction that prolonged PCC participation increases parents' awareness of the need for providing more than just physical care in order to ensure that the baby will "turn out just fine." Data for involvement do, however, bear out this expectation. Among rural participants at both T1 and T2, highly involved parents were significantly more likely to disagree with the statement than were less involved parents. No significant differences occurred among urban parents, however all findings were in the predicted direction.

3.3.2 "Most babies of a particular age are pretty much alike."

This item is intended to tap another fundamental aspect of PCC philosophy. All PCC's state that, in teaching child development to mothers, they stress the individuality of the growth pattern of each particular baby. Thus, PCC mothers, particularly those who are long-time parents, should disagree strongly with this item.

Within the urban subsample, an unexpected difference occurred over time. Significantly fewer new urban members were likely to disagree with the statement at T2 than at T1. Whereas at T1, 58% of the new subjects disagreed with the item, at T2 only 23% were in disagreement. A significantly greater proportion of long-time parents disagreed with the idea presented than was the case with short-time parents at T1, and new and short-time members at T2. These findings are supportive of the prediction discussed above. However, given these findings, it is surprising to note that at T2 as many as 35% of the long-time urban parents agreed with the statement that most babies of a particular age are pretty much alike.

Data on the rural subsample and those on involvement show no consistent differences.

3.3.3 "Babies can't learn much before the age of one."

Since PCC stresses the need for stimulation of infants and demonstrates to mothers how much babies can do, it was predicted that ongoing PCC mothers would take exception to this statement.

This prediction is not borne out by the data on the urban subsample. At T2, new urban parents tended to disagree with this item significantly more than did short-time parents. Although the differences are not significant, at both T1 and T2, new urban parents were the subgroup most likely to take exception to this statement.

In general, rural respondents tended to disagree (96% at T2) with the idea that babies cannot learn much before the age of one in greater proportion than did their urban counterparts (81% at T2). Long-time rural parents significantly increased in their disagreement with the statement from T1 to T2. At T2, none (0%) of these participants agreed with this notion. This increased knowledge over time produced a significant difference between long and short-time rural respondents at T2.

At T1, significantly more urban and rural highly involved parents disagreed with the statement than did less involved subjects. While these differences are not statistically significant at T2, they remain in the predicted direction.

3.3.4 "Babies of about a year and a half aren't interested in books. They just tear them."

This item, like the previous items, was intended to measure parental understanding of the young child's need for, and ability to respond to, stimulation. Thus, it was predicted that ongoing parents would answer this item in the negative.

No differences are statistically significant. However, the same trends which have been apparent throughout this set of "knowledge" items are evident. Fewer of the highly involved parents, either urban or rural at either T1 or T2, agree with the statement.

Among the urban and rural subsamples, there are no differences between new and old members on this dimension. It is, however, surprising to see that at T2, 26% of the urban and 18% of the rural long-time parents agree with the statement.

3.3.5 "Being a good mother is a really important job."

A fundamental effort of PCC is directed toward helping mothers to understand their singular importance. During interviews, CCR interviewers often heard mothers explain that PCC had helped them to experience their own centrality and significance, specifically as mothers. Thus, it was predicted that the highly involved and long-time mothers would evince strong support for this statement.

The overwhelming majority of both urban (98% at T2) and rural (96% at T2) respondents agreed with this item. Within the urban subsample at T1, new and long-time members agreed with the statement in significantly greater proportions than did short-time members. These differences were not maintained at T2. Rural long-time members increased significantly from T1 to T2 in their agreement with the statement, but again, there were no subgroup differences of note. Differences between high and low involved subjects in both subsamples at both interview times are negligible as virtually everyone agrees with the statement.

3.4 Summary of parenting attitudes, behavior and feelings.

FEELINGS OF ADEQUACY AS A PARENT

There is some evidence to suggest that PCC participation makes parents more likely to question their adequacy as parents. It was suggested that as parents become increasingly aware of the complexities of parenting they become more self-critical and demanding. Changes in this direction are not consistent and it should be noted that the vast majority of parents in all subgroups report feeling basically satisfied with the adequacy of their parenting performance.

PARENTING BEHAVIOR

No changes in parenting behavior, in terms of holding the baby during feedings, amount of time the baby is kept in his crib, and the amount of verbal companionship provided to babies at mealtime, are evidenced by any subgroup over time. The vast majority of all mothers report that they hold their babies during feedings most of the time, that they keep their babies in their cribs only occasionally or not at all, and that they provide verbal companionship at meals at least a good deal of the time.

ATTITUDES AND KNOWLEDGE OF CHILD DEVELOPMENT

There is little evidence to support the hypothesis that PCC has an impact on parental understanding of child development or on sensitivity to individual differences in children.

CHAPTER V

SELF-CONCEPT

1.0 Description of items

Fifteen items, which require a response along a five-point Likert scale, were used as the basis for data collection.

Three items were developed to measure the respondents' general outlook on life: is the world basically friendly, does it hold positive potential? Item contents were based on scales of anomie or alienation:

- "You can trust most people."
- "The future looks bright for today's children."
- "My children are going to have a lot more than I do."

Each of the above was measured on a scale of relative agreement or disagreement.

The next group of three items was intended to measure feelings of social isolation or affiliation:

- "I feel all alone in the world."
- "I need to be with people."
- "I tend to feel shy with people."

Each of these three was measured on a scale of frequency ranging from "most of the time or always" to "seldom or never."

The next six were intended to measure perceived power or competence:

- "What happens to me is my own doing."
- "When I make plans, I am pretty sure they will work."
- "I don't like to make decisions."
- "There's not much I can do to change the way things are."
- "Doing anything about a happier future is just a waste of time."
- "There's no use in planning for tomorrow. All we can do is live for the present."

Each of the above was accompanied by a scale of relative agreement/disagreement.

The final three items were intended as measures of behavior. These deal with Ss' self-reports of their concern or involvement in public affairs:

- "I vote in local and national elections."
- "I get involved in community affairs."
- "I talk to others about the needs of this community."

These require responses on a scale of frequency: "Most of the time or always" to "seldom or never."

Responses were scored so that the greater the frequency of the of the behavior or the greater the degree of agreement, the higher the score. Thus, "most of the time or always" on the frequency scale and "strongly agree" on the agreement/disagreement scale would be scored as 5, and so on down to 1 at the other end.

It was assumed that agreement or high frequency reported for positively stated items would be indications of positive self-concept or community participation. However, six of the items are stated negatively, in which cases disagreement or infrequency would be associated with positive report. That causes a problem in comparing mean scores on items. To make all means readily comparable, scoring was reversed for those six items, so that, uniformly, the greater the mean, the more positive the attitude or the reported behavior.

A factor analysis was performed on the T1 data and the results were reported in the Interim Report. T2 data analysis revealed a markedly altered factor structure, particularly in the rural data. Since the factor structure at T1 is markedly different from the factor structure in T2 it is impossible to make T1 vs T2 comparisons in terms of factor scores. For this reason all comparisons presented on these data are in terms of mean score differences at the item level. All P levels reported are for one-tailed t-tests.

2.0 Changes over time in self-concept

2.1 Changes in general outlook

Table V-1a. Means and standard deviations on items related to general life outlook - urban.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "You can trust most people."	M	2.58	2.65	2.33	2.35	2.71	2.51
	SD	.93	1.04	.92	1.07	1.02	1.11
2. "The future looks bright for today's children."	M	3.46	3.93	3.39	3.81	3.95	3.63
	SD	1.15	.91	1.14	.88	.71	1.01
3. "My children are going to have a lot more than I do."	M	4.38	4.24	4.23	4.11	4.15	4.14
	SD	.68	.86	.64	.80	.96	.82

Item 1. t2-3 = 1.68; P= <.05

Item 2. t1-2=-1.99; P= <.05
t2-3= 2.72; P= <.05
t5-6= 1.92; P= <.01

Table V-1b. Means and standard deviations on items related to general life outlook - rural.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) New	(2) Short	(3) Long	(4) New	(5) Short	(6) Long
1. "You can trust most people."	M	3.21	3.00	3.21	3.00	2.79	3.39
	SD	.86	.89	1.22	1.07	1.05	.95
2. "The future looks bright for today's children."	M	2.86	3.50	3.54	3.00	3.29	3.64
	SD	.99	.82	.82	1.07	.99	1.07
3. "My children are going to have a lot more than I do."	M	3.50	3.64	4.03	3.57	3.54	4.00
	SD	.73	.81	.72	1.05	1.12	.89

Item 1. t5-6= -2.34; P= <.05

Item 2. t1-2= -2.17; P= <.05
t1-3= -2.42; P= <.01
t4-6= -1.83; P= <.05

Item 3. t1-3= -2.25; P= <.05
t2-3= -1.95; P= <.05
t5-6= -1.78; P= <.05

2.1.1 "You can trust most people."

In terms of this item, there are no important differences between urban longevity groups either in T1 or in T2. Similarly, there are no differences within groups over time. More new parents than long-term parents in T1 tend to agree that most people are to be trusted. In T1, long-term parents are the least trusting and the difference between them and short-time parents is statistically significant. No group became significantly more or less trusting as a result of one program year.

Unlike their urban counterparts, long-time rural members are the most trusting subgroup. In T2, there was a significant difference between them and short-time members. While no significant differences occurred in T1, it can be seen that short-time members here too report themselves as being less trusting of others. Apparently, this particular subgroup of short-term members is generally less trusting of others than are new and long-time members and this is a difference which holds up at T1 and T2.

2.1.2 "The future looks bright for today's children."

Within the urban subsample in T1, significantly more short-time members agreed with the statement that the future looks bright for today's children than did either new or long-time members. In T2, there is a statistically non-significant trend for new and long-term parents to have become more optimistic over the course of the program year. However, in T2, short-term members are still significantly more likely to agree with the statement than is the case among long-time participants. In other words, short-time parents who were more optimistic in T1 continue to be more optimistic in T2.

Among rural respondents, new members constitute the least optimistic subgroup. In T1, new parents were significantly less optimistic about their children's future than were either short or long-term parents. The difference between new and long-time members was also maintained at T2.

2.1.3 "My children are going to have a lot more than I do."

The data show no difference within the urban subsample at either T1 or T2 nor differences within subgroups over time. In other words, neither the new, the short-term, nor the long-term parents have altered their viewpoint in this regard. At both interview times the overwhelming majority (approximately 88%) of the urban respondents reported agreement with this statement.

Rural parents were generally less likely to agree with this statement (approximately 67%) than were their urban counterparts. Within the rural subsample, long-time members reported the most confidence in this statement and were the subgroup that most nearly met the urban level of optimism. At T1, these parents were significantly more optimistic about their children's futures than were new or short-term members. At T2, the difference between short and long-time members remained significant.

2.1.4 Summary

Based on these three items, the following conclusions can be drawn:

- There is no evidence that trust in other people changes as a function of PCC participation.
- Optimism about the future and what it holds for children is greater among ongoing than among new parents. However, there is no evidence that tenure in program has any impact on parental optimism regarding the future of their children: after one program year none of the subgroups shows any significant changes over time.

Involvement data on these items show no significant differences between low and high involved urban parents either in T1 or in T2. Of six possible comparisons (T1 urban high vs. low, T2 urban high vs. low for each of the three items) four are in the predicted direction, i.e., high involved parents tend to be more trusting and more optimistic about the future than are low involved parents.

Similarly, there were no differences in terms of involvement within the rural subsample. In three of the six comparisons, results are in the predicted direction, but all differences are minimal.

2.2 Changes in feelings of social isolation

Table V-2a. Means and standard deviations on items related to feelings of social isolation - urban.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) NEW	(2) SHORT	(3) LONG	(4) NEW	(5) SHORT	(6) LONG
1. "I feel all alone in the world."	M SD	3.89 1.42	4.02 1.33	4.14 1.15	4.50 .80	4.31 1.19	4.00 1.43
2. "I need to be with people."	M SD	3.00 1.33	3.14 1.28	3.04 1.43	2.73 1.26	3.17 1.35	3.29 1.26
3. "I tend to feel shy with people."	M SD	3.92 1.33	3.62 1.41	3.71 1.33	3.89 1.40	3.92 1.26	3.63 1.45

Item 1. t1-4 = 1.89; P= <.05

Item 2. t4-6 = -1.83; P= <.05

Table V-2b. Means and standard deviations on items related to feelings of social isolation - rural.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) NEW	(2) SHORT	(3) LONG	(4) NEW	(5) SHORT	(6) LONG
1. "I feel all alone in the world."	M SD	4.21 1.26	4.39 .67	3.94 1.25	4.21 .94	4.43 .86	4.32 .94
2. "I need to be with people."	M SD	3.36 1.11	3.07 1.13	3.45 1.28	2.79 .86	2.89 .90	3.45 1.10
3. "I tend to feel shy with people."	M SD	3.07 1.58	3.82 1.17	3.12 1.41	3.71 1.38	3.79 1.35	3.61 1.32

Item 2. t4-6 = -1.98; P= <.05
t5-6 = -2.11; P= <.05

Item 3. t1-2 = -1.70; P= <.05
t2-3 = 2.06; P= <.05

2.2.1 "I feel all alone in the world."

New urban parents report feeling significantly less alone in the world at T2 than they did at T1. In the first interview, 28% of these parents said that they felt alone more than half of the time. During the course of the program year the proportion of new members reporting similar feelings declined to 12%. For these particular members it is apparent that PCC participation has given them a new awareness of the availability of persons who care for them and are willing to help them.

There were no other statistically significant differences between any of the longevity subgroups either at T1 or at T2. Moreover, no other significant differences occurred within any of the groups over time. In general, the majority of parents (78% at T1, and 86% at T2) report that they "feel all alone in the world" seldom or occasionally.

2.2.2 "I need to be with people."

In both the urban and rural subsamples at T2, significantly more long-time members report that they need to be with people than is the case with new members. Among rural respondents, the difference between long and short-time members at T2 is also significant in the same direction. Differences within subgroups were not significant at T1 nor did any group change significantly over time. It is interesting to note however, that although the change is not significant, fewer new parents, both urban and rural, report that they need to be with people at least half of the time in T2 (62%)

than was true in T1 (46%). It is possible that, once being assured that companionship was available to them at the PCC, the need for this companionship diminished.

2.2.3 "I tend to feel shy with people."

Among rural respondents at T1, short-time members were significantly less shy than were either new or long-time members. These differences were not maintained at T2, at which time there were virtually no differences between subgroups.

Within the urban subsample, there are no statistically significant differences between any of the longevity subgroups at T1 or at T2. Moreover, no group, either urban or rural, changed significantly in the course of the program year. In general, the majority of respondents report that they "tend to feel shy with people" occasionally.

2.2.4 Summary

Based on these three items the following conclusion can be drawn about feelings of social isolation:

° The changes measured by these three items are not sufficiently consistent to say with confidence that PCC has a specific impact on feelings of aloneness, shyness or the need to be with others.

In terms of involvement, there are no statistically significant differences between high and low involved urban parents at T1 or T2. Three of the six differences are in the predicted direction, but the trend is minimal. Differences between high and low involved rural parents are also not statistically significant at either T1 or T2. High involved parents are somewhat more likely to report that they need to be with others and are less likely to feel shy than are low involved parents. It seems likely that the personal qualities which make people less shy and dependent on their relationships with others, also enable them to become more actively involved in PCC.

2.3 Changes in feelings of personal power, competence and control.

Table V-3a. Means and standard deviations on items related to feelings of personal power, competence and control - urban.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) NEW	(2) SHORT	(3) LONG	(4) NEW	(5) SHORT	(6) LONG
1. "What happens to me is my own doing."	M SD	3.54 1.25	3.50 1.10	3.75 1.23	3.38 1.44	3.60 1.43	4.14 1.08
2. "When I make plans, I am pretty sure they will work."	M SD	3.00 1.24	3.65 1.12	3.35 1.12	3.35 1.17	3.57 1.26	3.51 1.16
3. "I don't like to make decisions."	M SD	3.46 1.39	3.40 1.29	3.37 1.28	3.77 1.05	3.55 1.37	3.49 1.33
4. "There's not much I can do to change the way things are."	M SD	3.42 1.08	3.26 1.28	3.04 1.25	3.42 1.08	3.33 1.22	3.37 1.07
5. "Doing anything about a happier future is just a waste of time."	M SD	3.85 1.03	4.07 1.13	3.96 1.01	4.39 .79	4.05 .95	3.78 1.16
6. "There's no use in planning for tomorrow; all we can do is live for the present."	M SD	3.58 1.18	3.17 1.23	3.49 1.24	3.69 1.07	3.14 1.25	3.49 1.23

Item 1. t3-6=-1.69; P= <.05
t4-6=-2.53; P= <.01
t5-6=-2.16; P= <.05

Item 2. t1-2=-2.36; P= <.05

Item 5. t1-4=-2.08; P= <.05
t4-6= 2.34; P= <.05

Item 6. t4-5=-1.94; P= <.05

Table V-3b. Means and standard deviations on items related to feelings of personal power, competènce and control - rural.

ITEM		TIME 1			TIME 2		
		LENGTH OF			MEMBERSHIP		
		(1) NEW	(2) SHORT	(3) LONG	(4) NEW	(5) SHORT	(6) LONG
1. "What happens to me is my own doing."	M	4.29	3.86	3.73	4.14	3.79	3.58
	SD	.96	.91	1.35	.83	1.01	1.33
2. "When I make plans, I am pretty sure they will work."	M	3.07	2.93	3.48	3.36	3.07	3.48
	SD	1.22	1.13	1.23	1.23	1.16	1.39
3. "I don't like to make decisions."	M	3.86	3.54	3.24	3.50	3.36	3.36
	SD	.92	1.15	1.21	1.24	1.20	1.18
4. "There's not much I can do to change the way things are."	M	3.43	3.50	3.58	3.21	3.71	3.52
	SD	1.12	1.05	1.10	1.26	.99	1.13
5. "Doing anything about a happier future is just a waste of time."	M	3.93	3.89	4.15	4.29	4.21	4.12
	SD	.70	1.01	.61	.88	.94	.64
6. "There's no use in planning for tomorrow; all we can do is live for the present."	M	3.79	3.29	3.39	3.86	3.32	3.91
	SD	.94	1.13	1.07	1.06	1.07	1.08

Item 2. t2-3=-1.79; P= <.05   Item 6. t3-6=-1.91; P= <.05
t5-6=-2.09; P= <.05

2.3.1 "What happens to me is my own doing."

In T2, significantly more long-time urban members report feeling a sense of personal control over their own destiny than was true in T1. This increase produced significant differences in T2 that were not previously present. At T2, significantly more long-time than new or short-time urban members report "what happens to me is my own doing." No other significant differences occurred between subgroups or over time in either the urban or rural subsamples.

2.3.2 "When I make plans, I am pretty sure they will work."

Within the urban subsample at T1, short-time members report significantly greater confidence in their ability to make successful plans than is true of new parents. Among rural respondents at this time, significantly more long-term than short-term members report similar feelings. In both subsamples it is the new parents who evince the least amount of confidence in this area. It is interesting to note that at T2 these new parents increased in their feelings of competence to the extent that previous differences are no longer significant.

2.3.3 "I don't like to make decisions."

There are no statistically significant differences, urban or rural, between longevity subgroups at T1 and T2 or over time. However, among rural respondents at T1, the difference between new and long-term members almost reaches statistical significance. New rural parents report a greater readiness to make decisions than do long-term parents. At T2, a smaller proportion of new parents and a slightly higher proportion of long-term members reported a willingness to make decisions, thus obliterating the T1 difference. All urban longevity subgroups increased slightly over time in their readiness to effect decisions.

2.3.4 "There's not much I can do to change the way things are."

This item, designed to tap feelings of control over one's life, produced no significant differences either between subgroups or over time. At both T1 and T2 approximately 60% of all respondents report that they disagree with the statement. While the differences are not significant, it is interesting to note that among urban respondents new parents evince the greatest optimism whereas their rural counterparts are the most pessimistic subgroup.

2.3.5 "Doing anything about a happier future is just a waste of time."

New urban parents increased significantly over time in their confidence in planning for the future. At T2, these parents were significantly more optimistic about working toward a happier future than were long-time urban members. New and short-term rural members reported an increased sense of optimism over time, but the changes are not significant. No other significant differences occurred either between groups or over time in the two subsamples.

2.3.6 "There's no use in planning for tomorrow; all we can do is live for the present."

Significantly more new urban members disagreed with this statement than did short-term members at T2. While differences between the urban subgroups were not significant, in T1, new parents were again the group who most felt that there is a purpose to planning for the future.

A significant difference occurred over time among long-term rural parents. During the course of the program year, these parents became more convinced of the usefulness of planning. At T2, the difference between long and short-term members was also significant. It is interesting that although the differences between groups are not significant at T1, here too, new parents are the most optimistic and, in a manner similar to their urban counterparts, their optimism increased over time.

2.3.7 Summary

Based on these items the following conclusions can be drawn:

- There is evidence that PCC has an impact on parents' feelings that they have control over their destiny or over their sense of personal helplessness.
- Some differences do exist between subgroups, but there are only two changes over the program year. In terms of predicted changes in new parents, there is a significant difference (urban) on one of the six items

and a trend in the right direction on 3 more. Similarly, there is one T1 vs T2 difference that is statistically significant for long-term (rural) members and 3 items in which changes in both short and long-term parents are in the predicted direction.

Analysis of the involvement data for the urban subsample show no significant differences between high and low involved parents in T1 or in T2. Among rural respondents, high involved parents are more likely to have a sense of confidence that their plans will work than are low involved parents. These differences are significant in T2, but not in T1. None of the other differences in involvement are significant for the rural subsample.

2.4 Changes in involvement in community affairs.

Table V-4a. Means and standard deviations on items related to involvement in community affairs - urban.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) NEW	(2) SHORT	(3) LONG	(4) NEW	(5) SHORT	(6) LONG
1. "I vote in local and national elections."	M SD	2.50 1.87	2.38 1.85	2.78 1.74	3.19 1.78	3.07 1.70	3.43 1.73
2. "I get involved in community affairs."	M SD	2.11 1.37	2.40 1.30	2.63 1.55	2.65 1.52	2.53 1.48	3.04 1.53
3. "I talk to others about the needs of this community."	M SD	2.58 1.52	3.09 1.51	3.06 1.53	2.81 1.49	2.91 1.36	3.51 1.54

Item 1. t2-5=-2.07; P=<.05
t3-6=-1.86; P=<.05

Item 2. t5-6=-1.73, P=<.05

Item 3. t4-6=-2.13; P=<.05

Table V-4b. Means and standard deviations on items related to involvement in community affairs - rural.

		TIME 1			TIME 2		
		LENGTH OF MEMBERSHIP					
ITEM		(1) NEW	(2) SHORT	(3) LONG	(4) NEW	(5) SHORT	(6) LONG
1. "I vote in local and national elections."	M SD	2.29 1.75	3.36 1.82	2.64 1.77	2.57 1.84	3.50 1.76	3.18 1.78
2. "I get involved in community affairs."	M SD	1.50 .63	2.46 1.48	2.73 1.48	1.79 .94	2.25 1.27	2.76 1.52
3. "I talk to others about the needs of this community."	M SD	2.07 1.03	2.57 1.29	3.00 1.21	2.07 1.16	2.57 1.24	2.70 1.27

Item 1. t1-2=-1.78;P=<.05

Item 2. t1-2=-2.28;P=<.05
t1-3=-2.92;P=<.01
t4-6=-2.17;P=<.05

Item 3. t1-3=-2.46;P=<.01

2.4.1 "I vote in local and national elections."

A significantly greater proportion of short and long-term urban parents report that they vote in elections at T2 than was true at T1. Among rural respondents, new parents were the least likely to vote and at T1 the difference between this subgroup and short-term members was statistically significant. In general, the majority of all respondents report they vote in local and national elections about one-half of the time or less often.

2.4.2 "I get involved in community affairs."

Within the urban subsample at T2, significantly more long-term members report involvement in community affairs than is the case with short-term participants. Differences between urban subgroups were not significant at T1, however, the trend was in the same direction: new parents were least likely to involve themselves in community affairs, followed by short-term and then long-term members. It should be noted however, that at T1 only 28% of the new urban members reported involvement more than half of the time, whereas at T2 similar reports were received from 50% of these parents.

Although new rural parents also increased slightly over time in their reported readiness to get involved in community affairs, at T1 they were significantly less likely to engage in such activities than were either short or long-term parents. The difference between new and long-term rural parents was maintained in T2.

No group, either urban or rural, changed significantly along this dimension in the course of the program year.

2.4.3 "I talk to others about the needs of this community."

At both T1 and T2, new parents, urban and rural, were less likely to talk to others about the needs of their particular communities than were short and long-term PCC participants. Within the rural subsample this tendency to shy away from community involvement produced a significant difference between new and long-term members at T1. This same type of difference occurred between new and long-term urban members in T2. In general, the majority of respondents report that they speak to others about the needs of the community only slightly more often than occasionally.

2.4.4 Summary

Based on these three items the following conclusion can be drawn:

- In general involvement in community affairs is low for all respondents and no groups changed significantly over time. However there is slight evidence to show that prolonged participation in PCC may increase the level of community engagement. Ongoing members consistently reported greater involvement than did new parents at both T1 and T2. With the exception of rural parents on one item, new parents showed some T1 to T2 gains.

In terms of involvement, at T1 significantly more high involved than low involved urban parents reported that they vote in elections, that they get involved in community affairs and that talk to others about the needs of their community. In T2, differences are statistically significant only on the item, "I get involved in community affairs." Differences between high and low involved parents on the other items are in the predicted direction.

Parents who are highly involved in PCC tend to be more involved in local community affairs. There is no firm evidence, however, to suggest causality, i.e., that involvement in PCC makes people more involved in their community. The alternative explanation, i.e., that some people are more prone to get involved than others and thus they become involved in PCC as one manifestation of this tendency, is just as likely.

In marked contrast to the urban subsample, among rural respondents there are no significant differences in terms of involvement on any of these items. Apparently, among rural parents there is no relationship between their involvement in PCC and their involvement in the affairs of the community at large.

CHAPTER VI

KNOWLEDGE AND USE OF COMMUNITY RESOURCES

1.0 Introduction

A major goal in working with parents at any PCC is to provide an environment in which competencies and self-sufficiency can be enhanced and developed. Thus, the PCC must address its efforts not only to parenting skills per se, but also to developing skills necessary to affect the institutional systems which have relevance to the family. The PCCs and their participants do not exist in a vacuum, but rather in communities where various organizations respond to and influence the availability and quality of services. Staff members and Social Service Coordinators assist parents in negotiating these systems to ensure adequate service delivery. Ideally, however, such assistance is seen as a temporary and interim step in teaching parents to independently seek out, utilize, and affect services. The data presented in this chapter show any changes in the variety of resources used by PCC members and any changes in their knowledge of the existence of these resources over time.

2.0 Membership in community groups

The PCCs are governed by a parent-controlled body, the Policy Advisory Council (PAC). Thus, they offer a wide range of opportunities and activities in which parent inputs are of primary concern. During parent education sessions, PAC meetings, and group discussions, parents' ideas and suggestions are basic to program operation; parents are affecting the system of which they are a part. Such ongoing participation is designed to promote increased self-confidence among parents. It is expected that the parents will generalize from this PCC experience and become vocal, active participants in other community boards and organizations that impinge upon their lives and those of their families.

Table VI-1a. Membership in community groups - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Head Start Policy Council	N	8	1	3	4	12	-	4	8
	%	(6)	(4)	(5)	(8)	(9)	-	(7)	(16)
P.T.A.	N	19	1	6	12	19	2	5	12
	%	(14)	(4)	(10)	(23)	(14)	(8)	(9)	(23)
Scouts or other youth groups	N	8	1	4	3	9	2	2	5
	%	(6)	(4)	(7)	(6)	(7)	(8)	(3)	(10)
Church-related clubs	N	31	4	15	12	34	5	14	15
	%	(23)	(15)	(26)	(23)	(25)	(19)	(24)	(30)
Hospital volunteer	N	1	-	-	1	4	1	1	2
	%	(*)	-	-	(2)	(3)	(4)	(2)	(4)
Political organization	N	4	1	3	-	6	1	4	1
	%	(3)	(4)	(5)	-	(4)	(4)	(7)	(2)
Other	N	31	3	14	14	29	7	9	13
	%	(23)	(11)	(25)	(27)	(21)	(27)	(16)	(25)
Belong to club or organization	N	60	9	27	24	68	12	28	28
	%	(44)	(35)	(45)	(47)	(51)	(46)	(47)	(55)
Belong to no club or organization	N	75	17	31	21	67	14	30	23
	%	(56)	(65)	(55)	(53)	(49)	(54)	(53)	(45)
Base		135	26	58	51	135	26	58	51

(*) less than 1%

Note: percentages do not total 100 as multiple responses occurred.

Table VI-1b. Membership in community groups - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Head Start Policy Council	N	5	1	-	4	6	-	1	5
	%	(7)	(7)	-	(12)	(8)	-	(4)	(15)
P.T.A.	N	6	1	2	3	7	3	-	4
	%	(8)	(7)	(7)	(9)	(9)	(21)	-	(12)
Scouts or other youth groups	N	5	-	3	2	10	1	5	4
	%	(7)	-	(11)	(6)	(13)	(7)	(18)	(12)
Church-related clubs	N	20	3	9	8	19	2	5	12
	%	(27)	(21)	(32)	(24)	(25)	(14)	(18)	(36)
Hospital volunteer	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Political organization	N	1	-	1	-	-	-	-	-
	%	(1)	-	(4)	-	-	-	-	-
Other	N	10	1	5	4	15	-	5	10
	%	(13)	(7)	(18)	(12)	(20)	-	(18)	(30)
Belong to club or organization	N	32	6	13	13	32	4	10	18
	%	(43)	(43)	(46)	(40)	(43)	(30)	(36)	(55)
Belong to no club or organization	N	43	8	15	20	43	10	18	15
	%	(57)	(57)	(54)	(60)	(57)	(70)	(64)	(45)
Base		75	14	28	33	75	14	28	33

Note: percentages do not total 100 as multiple responses occurred.

Overall, there appears to be a very slight increase in community group membership from T1 to T2, although the majority of respondents (56% at T1; 52% at T2) report no affiliation with any clubs or organizations. The number of persons involved in community groups remained fairly stable; some shift occurred in the category of membership reported.

As in T1, the T2 data show that the most frequently reported form of participation is membership in church-related clubs and groups. It is not surprising that this category represents the highest percentage of parent involvement, as these groups are the "easiest" to join, given that many persons have been part of a church for most of their lives. In both the urban and rural subsamples, membership tends to be highest among long-term respondents and there is a slight increase in the number of members from T1 to T2.

Although Parent-Teacher Associations represent the next highest percentages overall, the proportion of PCC parents reporting to be members of a P.T.A. is low. As in T1, involvement in the P.T.A. is greater in T2 for urban respondents than it is for rural subjects. The overall higher degree of P.T.A. participation among long-time members is expected, as they are the group with the oldest children and, hence, have the greatest opportunities for involvement in this organization.

Participation rates in a Head Start Policy Council are highest in both subsamples, at both times, for long-term members. This was again expected, as long-term parents are older and have older children than do the short-term or new families. Still, the proportion of parents (approximately 7%) participating in a Head Start Policy Council is low. It could be expected that

Head Start involvement is the natural follow-up to and outlet for experiences gained through PCC participation as both programs are similar in organization, structure, and content. The data do not support this hypothesis.

Participation in the remaining groups: Scouts, hospital volunteer work, and political organizations, show virtually no change over the one year period of the evaluation.

Persons reporting to be members of "other" community groups listed a wide variety of organizations: block associations, ethnically-oriented groups, bowling leagues, veterans' groups, school volunteers, missionary work, etc. The T1 to T2 differences in this category are slight.

Motivating parents to participate in community groups is a complex process that is not dependent upon any one factor. Possible factors in addition to parental self-confidence and interest include: visibility of community groups, ease of transportation to meeting place, geographic proximity of families which can promote sociability and outgoing qualities needed for group participation, and responsibilities placed upon participants.

3.0 Number of respondents and/or spouses taking courses and level of these courses.

As part of their effort to increase the competence and skills of parents, many PCCs have stressed their efforts to enroll parents in formal education. This may involve G.E.D. classes, college courses, or continuing adult education classes.

Table VI-2a. Number of respondents and/or spouses taking courses and level of these courses - urban.

		TIME 1				TIME 2*			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
TAKING COURSES	N	33	8	18	7	37	13	11	13
	%	(24)	(31)	(31)	(14)	(27)	(50)	(19)	(25)
Adult Education	N	13	2	8	3	16	4	3	9
	%	(39)	(25)	(44)	(43)	(43)	(31)	(37)	(69)
High school courses	N	9	3	4	2	6	2	3	1
	%	(27)	(37)	(22)	(29)	(16)	(15)	(37)	(8)
College courses	N	11	3	6	2	15	7	5	3
	%	(33)	(37)	(33)	(29)	(41)	(54)	(46)	(23)
NOT TAKING COURSES	N	102	18	40	44	98	13	47	38
	%	(76)	(69)	(69)	(86)	(73)	(50)	(81)	(75)
Base		135	26	58	51	135	26	58	51

* chi-square significant at .05 level

Note: percentages for type of course are based on number of respondents and/or spouses taking courses.

Table VI-2b. Number of respondents and/or spouses taking courses and level of these courses - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
TAKING COURSES	N	23	2	7	14	15	4	4	7
	%	(31)	(14)	(25)	(42)	(20)	(29)	(14)	(21)
Adult Education	N	13	1	6	6	5	1	2	2
	%	(57)	(50)	(86)	(43)	(33)	(25)	(50)	(29)
High school courses	N	3	-	-	3	4	2	1	1
	%	(13)	-	-	(21)	(27)	(50)	(25)	(14)
College courses	N	7	1	1	5	6	1	1	4
	%	(30)	(50)	(14)	(36)	(40)	(25)	(25)	(57)
NOT TAKING COURSES	N	52	12	21	19	60	10	24	26
	%	(69)	(86)	(75)	(58)	(80)	(71)	(86)	(79)
Base		75	14	28	33	75	14	28	33

Note: percentages for type of course are based on number of respondents and/or spouses taking courses.

In both T1 (73%) and T2 (76%), the majority of respondents reported that they are not enrolled in any type of education program. Across this time period, no significant shifts are noted. Among new members, four urban and two rural parents enrolled in some type of course.

A slight decline in enrollment is apparent among both short and long-time rural respondents. Whereas in T1 the majority of rural respondents taking courses were enrolled in adult education courses, T2 data show a slight increase in high school and college level enrollment. This shift many be due in part to completion of one set of courses and enrollment in the next sequence of classes.

Within the urban subsample at T2, a significant difference between the three subgroups exists. At this time, proportionately more new than short or long-term members are enrolled in course work.

Table VI-2c. Enrollment in courses with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL*	NEW	SHORT	LONG	TOTAL*	NEW	SHORT	LONG
Enrolled with PCC help	N	10	3	3	4	11	2	3	6
	%	(27)	(23)	(27)	(31)	(73)	(50)	(75)	(86)
Enrolled without PCC help	N	27	10	8	9	4	2	1	1
	%	(73)	(77)	(73)	(69)	(27)	(50)	(25)	(14)
Base: number of persons enrolled in courses		37	13	11	13	15	4	4	7

*Chi-square significant at .05 level.

Of the 52 urban and rural respondents enrolled in education programs in T2, 21 (40%) report that they did so with PCC involvement. Involvement, as the term is used here, may entail encouragement, motivational efforts, information, or referral. In the case of PCC parent-staff members, involvement may also mean that the PCCs require staff to enroll in course work in order for them to maintain their positions at the Center. Caution is urged in interpreting the PCC involvement data in too stringent a manner. The data presented in this area stem from respondents' self-reports, some of which may cover a time period of over a year. It therefore seems unreasonable to expect that persons will remember every instance in which the PCC facilitated a referral or performed some action that made the delivery of a service or enrollment in a program possible.

Although the numbers within a given cell in Table VI-2c are quite small, there are some trends apparent. Proportionately fewer rural than urban parents are enrolled in course work; however, a significantly greater percentage of rural respondents attribute their enrollment to PCC. In both the urban and rural subsamples, it is the long-time members who report the highest degree of PCC involvement. As a group, long-time members have completed the least number of years of education and may, in fact, be in most need of PCC assistance in this area. They are an older group, which means they may have been away from the classroom for a number of years. For these reasons, long-time members may need the extra encouragement and motivation provided by the PCC in order to help them feel confident within the educational system. The new urban and rural parents present a different case. In both subsamples, new members have the highest percentages for enrollment in educational courses and the lowest percentages for PCC involvement. Again, the numbers in each cell are small. However, several PCC staff members have expressed the feeling that the programs' new participants are more independent, more vocal, and more self-motivated than were previous incoming members. The data tend to lend some support to this notion, at least in relation to educational involvement.

4.0 Knowledge and use of available community resources

This section of the questionnaire is designed to measure the knowledge and utilization of fifteen different community resources, most of which are available in most locations. Interviewers asked subjects if each resource, individually, was available in their community. If a positive reply was received, the interviewer then asked if the respondent had ever used the resource. The data presented for resources available and used should not then be interpreted to mean that respondents are necessarily using this resource at the present time. Although this may be true in some cases, most notably basic supportive services, day care programs, Head Start, Legal Aid, and job training programs, it is also possible that respondents are referring to single (or multiple) incidences of use in the past.

In T2, a third dimension was added: if a respondent replied that a resource was available and used, the interviewer then asked if the PCC was involved in connecting the parent with the service. Data obtained from this portion of the questionnaire are presented in Tables separate from those pertaining to knowledge and use of the relevant resource.

The measure of awareness of resources is obtained by combining those subjects who say it is available and has not been used with those subjects who say it is available and that they have used it. The measure of non-awareness of a resource is obtained by combining those subjects who say they "don't know" if a resource exists with those who state that it is "not available" when, in fact, it is.

Use of resource is considered separately from knowledge. In measuring use of resource, only those subjects who were aware of the resource's availablility were included in the data analyses. Respondents reporting that the resource was available and that they had used it were compared with those who reported availability and non-use. In cases where cell sizes were sufficient, chi-square analyses were completed for each resource. Analyses were performed separately for the urban and rural subsamples. Actual comparisons are as follows:

- New vs. short-time vs. long-time families in T1.
    - Knowledge of resource
    - Use of resource

- New vs. short-time vs. long-time families in T2.
    - Knowledge of resource
    - Use of reource

- High vs. low involved families in T1.
    - Knowledge of resource
    - Use of resource

- High vs. low involved families in T2.
    - Knowledge of resource
    - Use of resource
- New families in T1 vs new families in T2.
    - Knowledge of resource
    - Use of resource
- Short-time families in T1 vs. short-time families in T2.
    - Knowledge of resource
    - Use of resource
- Long-time families in T1 vs. long-time families in T2.
    - Knowledge of resource
    - Use of resource
- Total urban sub-sample vs. total rural sub-sample.
    - Use of resource with PCC involvement

It is expected that PCC membership will increase knowledge of the resources available in the community. However, it does not follow that as a result of PCC membership parents will show increased service utilization in every case. The utilization of resources depends upon several factors, eligibility and need being the most important.

Given the demographic characteristics of the PCC sample population, it follows that the majority of participants would require services such as clinics, medicaid, and public assistance.

However, there is no similar expectation for services such as Legal Aid or child care programs; such resources are dependent upon individual needs. Longevity of membership should make a difference in participants' knowledge of the availability of resources, but again, not necessarily in their use. These considerations should be kept in mind when reviewing the subsequent data.

In addition, it had been expected that highly involved PCC participants would show an increased awareness of existing resources. Tables of involvement are not presented as these data yielded few significant differences in either T1 or T2. Where significant differences did occur, they are discussed in the narrative portion of the chapter.

4.1 Basic supportive services

The resources included in this section are food stamps, commodities, medicaid and welfare. Stringent eligibility requirements are associated with each; therefore, use vs. non-use often has less to do with longevity than with eligibility.

4.1.1 Knowledge and utilization of food stamps.

Table VI-3a. Knowledge and utilization of food stamps - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	9	2	4	3	5	1	3	1
	%	(7)	(8)	(7)	(6)	(4)	(4)	(5)	(2)
Not available	N	19	4	10	5	23	5	11	7
	%	(14)	(15)	(17)	(10)	(17)	(19)	(19)	(14)
AWARENESS									
Available & not used	N	41	6	21	14	40	5	22	13
	%	(30)	(23)	(36)	(27)	(30)	(19)	(38)	(25)
Available and used	N	66	14	23	29	67	15	22	30
	%	(49)	(54)	(40)	(57)	(50)	(58)	(38)	(59)
Receiving food stamps at time of interview	N	57	12	21	24	61	15	21	25
	%	(42)	(46)	(36)	(47)	(45)	(58)	(36)	(49)
Not receiving food stamps	N	78	14	37	27	74	11	37	26
	%	(58)	(54)	(64)	(53)	(55)	(42)	(64)	(51)
Base		135	26	58	51	135	26	58	51

Table VI-3b. Knowledge and utilization of food stamps - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Not available	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
AWARENESS									
Available and not used	N	19	2	8	9	23	3	8	12
	%	(25)	(14)	(29)	(27)	(31)	(21)	(29)	(36)
Available and used	N	56	12	20	24	52	11	20	21
	%	(75)	(86)	(71)	(73)	(69)	(79)	(71)	(64)
Receiving food stamps at time of interview	N	44	9	18	17	37	8	14	15
	%	(59)	(64)	(64)	(52)	(49)	(57)	(50)	(45)
Not receiving food stamps	N	31	5	10	16	38	6	14	18
	%	(41)	(36)	(36)	(48)	(51)	(43)	(50)	(55)
Base		75	14	28	33	75	14	28	33

Rural respondents at both T1 (75%) and T2 (69%) report extensive use of food stamps at some point. One-half of the urban subsample report having used food stamps at some time. These data should be viewed in conjunction with those on commodities, as in most locations food stamps and commodities are in an "either/or" relationship. That is, given a family's eligibility for one of these services, the family receives either food stamps or commodities, depending upon the policy of the local agency.

The proportion of respondents using food stamps over time is relatively stable. Among rural families slight differences are a function of seasonal employment. T1 interviews done in the late fall were conducted with families who could no longer work on the crops and who were receiving food stamps; T2 interviews in the spring occurred when some families were just beginning to work.

According to PCC staff, food stamps are available in all communities represented in the study. It is interesting that 21% of the urban respondents did not know of food stamps or thought they were not available (at both T1 and T2), whereas all rural respondents were aware of their availability, regardless of whether or not they used the resource.

Table VI-3c. Utilization of food stamps with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N %	8 (12)	2 (13)	2 (9)	4 (13)	9 (17)	3 (27)	3 (15)	3 (14)
Resource used without PCC involvement	N %	59 (88)	13 (87)	20 (91)	26 (87)	43 (83)	8 (73)	17 (85)	18 (86)
Base: all persons who have used food stamps	N %	67 (100)	15 (100)	22 (100)	30 (100)	52 (100)	11 (100)	20 (100)	21 (100)

The data presented in Table 3c show that only 14% of the people who received food stamps did so with some assistance from PCC program staff. The number of cases in which PCC has provided assistance is uniformly low across all subgroups. This is probably because most people who are receiving food stamps are also receiving some other form of public assistance, i.e., medicaid, welfare, commodities, and would therefore seek enrollment through their particular Department of Social Services (DSS) worker. Data on parental involvement in PCC showed no significant differences for either knowledge or use of this resource in either T1 or T2.

4.1.2. Commodities

Table VI-4a. Knowledge and utilization of commodities - urban**(1).

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	10	3	3	4	19	6	6	7
	%	(7)	(12)	(5)	(8)	(14)	(23)	(10)	(14)
Not available	N	31	5	6	20	20	2	3	15
	%	(23)	(19)	(10)	(39)	(15)	(8)	(5)	(29)
AWARENESS									
Available and not used	N	32	6	17	9	39	7	20	12
	%	(24)	(23)	(29)	(18)	(29)	(27)	(34)	(24)
Available and used	N	62	12	32	18	57	11	29	17
	%	(46)	(46)	(55)	(35)	(42)	(42)	(50)	(33)
Receiving commodities at time of interview	N	58	10	31	17	54	11	27	16
	%	(43)	(38)	(53)	(33)	(40)	(42)	(47)	(31)
Not receiving commodities	N	77	16	27	34	81	15	31	35
	%	(57)	(62)	(47)	(67)	(60)	(58)	(53)	(69)
Base		135	26	58	51	135	26	58	51

**(1) Chi-square significant at .01 level for knowledge of resource.

Table VI-4b. Knowledge and utilization of commodities - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	15	2	9	4	8	1	3	4
	%	(20)	(14)	(32)	(12)	(11)	(7)	(11)	(12)
Not available	N	50	9	14	27	57	9	22	26
	%	(67)	(64)	(50)	(82)	(76)	(64)	(79)	(79)
AWARENESS									
Available and not used	N	7	1	4	2	5	2	2	1
	%	(9)	(7)	(14)	(6)	(7)	(14)	(7)	(3)
Available and used	N	3	2	1	-	5	2	1	2
	%	(4)	(14)	(4)	-	(7)	(14)	(3)	(6)
Receiving commodities at time of interview	N	2	1	1	-	1	1	-	-
	%	(3)	(7)	(4)	-	(1)	(7)	-	-
Not receiving commodities	N	73	13	27	33	74	13	28	33
	%	(97)	(93)	(96)	(100)	(99)	(93)	(100)	(100)
Base		75	14	28	33	75	14	28	33

Commodities are available in two of the three rural communities in the sample, yet they are used by relatively few rural families. As was mentioned in the discussion on food stamps, a family usually receives either one or the other of these services, the decision being made on the basis of family eligibility and local policy. Commodities are a less convenient service in rural areas. Families must travel to a central distribution point in order to receive the food; in rural areas, where transportation is difficult and not readily available, this presents a problem.

Looking at the data in both Tables VI-3a&b (food stamps) and VI-4a&b (commodities), it can be seen that approximately ninety-three percent of the urban families and almost seventy-eight percent of the rural parents have used either food stamps or commodities at some time. In terms of current use (T2), 85% of the urban and 50% of the rural respondents are now receiving one or the other of these services. At any point in time, urban parents are the greater consumers of these two services combined. This may be more a function of local policy than of economic need. That is, given a rural and an urban family with equal incomes, it is possible that due to the differences in eligibility requirements between one locale and another, one family will receive food stamps or commodities while the other will not. In addition, employment tends to be greater among rural parents.

Approximately 45% of the long-time urban parents at both T1 and T2 report that the service is unknown to them or is unavailable in the community. Significantly fewer of the long-term urban parents know of the availability of the service than is the case with new and short-time members. Fewer long-time members use the service and apparently are therefore unaware of its existence.

Table VI-4c. Utilization of commodities with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N %	14 (25)	2 (18)	7 (24)	5 (29)	- -	- -	- -	- -
Resource used without PCC involvement	N %	43 (75)	9 (82)	22 (76)	12 (71)	5 (100)	2 (100)	1 (100)	2 (100)
Base: all persons who have used commodities	N %	57 (100)	11 (100)	29 (100)	17 (100)	5 (100)	2 (100)	1 (100)	2 (100)

Of the fifty-seven urban respondents who reported use of commodities at some time, one-quarter report PCC assistance in obtaining benefits. PCC assistance was most frequent among long-time members. In the rural subsample, none of the five persons who had received commodities reported any type of PCC involvement.

The data on parent involvement yielded no significant differences for either knowledge or utilization of commodities in either T1 or T2.

4.1.3. Medicaid

Table VI-5a. Knowledge and utilization of Medicaid - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	3	1	1	1	3	1	1	1
	%	(2)	(4)	(2)	(2)	(2)	(4)	(2)	(2)
Not available	N	2	-	1	1	-	-	-	-
	%	(1)	-	(2)	(2)	-	-	-	-
AWARENESS									
Available and not used	N	37	4	15	18	41	5	20	16
	%	(27)	(15)	(26)	(35)	(30)	(19)	(34)	(31)
Available and used	N	93	21	41	31	91	20	37	34
	%	(69)	(81)	(71)	(61)	(67)	(77)	(64)	(67)
Receiving Medicaid at time of interview	N	85	20	37	28	84	19	37	28
	%	(63)	(77)	(64)	(55)	(62)	(73)	(64)	(55)
Not receiving Medicaid	N	50	6	21	23	51	7	21	23
	%	(37)	(23)	(36)	(45)	(38)	(27)	(36)	(45)
Base		135	26	58	51	135	26	58	51

Table VI-5b. Knowledge and utilization of Medicaid - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	4	2	1	1	1	-	-	1
	%	(5)	(14)	(4)	(3)	(1)	-	-	(3)
Not available	N	-	-	-	-	1	-	-	1
	%	-	-	-	-	(1)	-	-	(3)
AWARENESS									
Available and not used	N	24	4	10	10	28	4	11	13
	%	(32)	(29)	(36)	(30)	(37)	(29)	(39)	(40)
Available and used	N	47	8	17	22	45	10	17	18
	%	(63)	(57)	(61)	(67)	(60)	(71)	(61)	(55)
Receiving Medicaid at time of interview	N	41	8	15	18	39	9	14	16
	%	(55)	(57)	(54)	(55)	(52)	(64)	(50)	(48)
Not receiving Medicaid	N	34	6	13	15	36	5	14	17
	%	(45)	(43)	(46)	(45)	(48)	(36)	(50)	(52)
Base		75	14	28	33	75	14	28	33

Well over 90% of both the urban and rural subsamples are aware of Medicaid availability. The majority of respondents reported that they had received Medicaid at some time.

Judging from the breakdown across longevity, it appears that knowledge and use of Medicaid are more a function of use of public assistance than of length of PCC membership.

Table VI-5c. Utilization of Medicaid with PCC involvement.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N	9	2	3	4	8	2	3	3
	%	(10)	(10)	(8)	(12)	(18)	(20)	(18)	(17)
Resource used without PCC involvement	N	82	18	34	30	37	8	14	15
	%	(90)	(90)	(92)	(88)	(82)	(80)	(82)	(83)
Base: all persons using Medicaid	N	91	20	37	34	45	10	17	18
	%	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)

The data presented for utilization of Medicaid with PCC involvement show that the vast majority (87%) of the total sample sought out this service without PCC assistance. Knowledge or use of Medicaid as related to level of involvement in PCC produced no significant differences.

4.1.4. Welfare

Table VI-6a. Knowledge and utilization of welfare - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	2	1	1	-	1	-	1	-
	%	(1)	(4)	(2)	-	(*)	-	(1)	-
Not available	N	-	-	-	-	1	1	-	-
	%	-	-	-	-	(*)	(4)	-	-
AWARENESS									
Available and not used	N	39	4	16	19	44	6	19	19
	%	(29)	(15)	(28)	(37)	(33)	(23)	(33)	(37)
Available and used	N	94	21	41	32	89	19	38	32
	%	(70)	(81)	(71)	(63)	(66)	(73)	(66)	(63)
Receiving welfare at time of interview	N	86	19	39	28	84	18	39	27
	%	(64)	(73)	(67)	(55)	(62)	(69)	(67)	(53)
Not receiving welfare	N	49	7	19	23	51	8	19	24
	%	(36)	(27)	(33)	(45)	(38)	(31)	(33)	(47)
Base		135	26	58	51	135	26	58	51

(*)less than 1%

Table VI-6b. Knowledge and utilization of welfare - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	1	1	-	-	-	-	-	-
	%	(1)	(7)	-	-	-	-	-	-
Not available	N	1	1	-	-	1	-	1	-
	%	(1)	(7)	-	-	(1)	-	(4)	-
AWARENESS									
Available and not used	N	37	6	16	15	35	5	14	16
	%	(49)	(43)	(57)	(45)	(47)	(36)	(50)	(48)
Available and used	N	36	6	12	18	39	9	13	17
	%	(48)	(43)	(43)	(55)	(52)	(64)	(46)	(52)
Receiving welfare at time of interview	N	29	6	11	12	33	8	13	12
	%	(39)	(43)	(39)	(36)	(44)	(57)	(46)	(36)
Not receiving welfare	N	46	8	17	21	42	6	15	21
	%	(61)	(57)	(61)	(64)	(56)	(43)	(54)	(64)
Base		75	14	28	33	75	14	28	33

Knowledge of this resource is widespread; over 60% of the total sample has used welfare at one time or another.

Looking at data reflecting actual receipt of welfare at T1 and T2, it can be seen that proportionately fewer rural than urban members receive welfare (39% at T1 and 44% at T2, as compared with 64% and 62% respectively). One contributing factor is the lower unemployment rate among rural families and the higher incidence of husbands in the home who are able to work. In addition, and perhaps more important, eligibility is defined locally rather than in terms of any absolute level of family income. In some areas, the amount of money available for welfare is dependent upon a county contribution of funds. Thus, a less wealthy county contributes a small amount of money that may not be sufficient to allow all needy families to receive welfare. It is therefore possible that given an urban and a rural family with the same incomes and resources one will receive welfare while the other will not.

Table VI-6c. Utilization of welfare with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N	6	2	2	2	6	2	1	3
	%	(7)	(11)	(5)	(6)	(15)	(22)	(8)	(18)
Resource used without PCC involvement	N	83	17	36	30	33	7	12	14
	%	(93)	(89)	(95)	(94)	(85)	(78)	(92)	(82)
Base: all persons who have used welfare	N	89	19	38	32	39	9	13	17
	%	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)

Given the high percentage of persons aware of this resource, PCC involvement in helping parents to obtain welfare is fairly low: 9% of the 128 persons who have used this service report PCC aid.

Involvement data for this resource also showed no significant or consistent differences.

4.2 Medical facilities

4.2.1 Health center or clinic

Table VI-7a. Knowledge and utilization of health center or clinic - urban

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	6	-	-	6	2	2	-	-
	%	(4)	-	-	(12)	(1)	(8)	-	-
Not available	N	3	1	1	1	4	-	1	3
	%	(2)	(4)	(2)	(2)	(3)	-	(2)	(6)
AWARENESS									
Available and not used	N	21	4	7	10	19	3	8	8
	%	(16)	(15)	(12)	(20)	(14)	(12)	(14)	(16)
Available and used	N	105	21	50	34	110	21	49	40
	%	(78)	(81)	(86)	(67)	(81)	(81)	(84)	(78)
Base		135	26	58	51	135	26	58	51

Table VI-7b. Knowledge and utilization of health center or clinic - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	16	3	7	6	1	-	-	1
	%	(21)	(21)	(25)	(18)	(1)	-	-	(3)
Not available	N	6	3	-	3	25	3	9	13
	%	(8)	(21)	-	(9)	(33)	(21)	(32)	(40)
AWARENESS									
Available and not used	N	10	2	3	5	13	3	6	4
	%	(13)	(14)	(11)	(15)	(17)	(21)	(21)	(12)
Available and used	N	43	6	18	19	36	8	13	15
	%	(57)	(43)	(64)	(58)	(48)	(57)	(46)	(45)
Base		75	14	28	33	75	14	28	33

According to PCC staffs, a health center is not available to residents of two rural PCC communities. It is therefore not surprising to find such major differences between the urban and rural subsamples, in terms of knowledge and use. The data for the first two categories of response substantiate the validity of interview data, as follows. At T1, 21% of the rural respondents reported that they "did not know" if the service was available and only 8% stated that a health center was not available. At T2, only one person responded "don't know" while 33% of the subjects in this subsample report non-availability of the service. As a health clinic is not available to a fair-sized portion of the rural subsample, this increase in the percentage of respondents reporting non-availability represents an increase in awareness of existing community resources.

Where services are available, the majority of respondents are making use of the resource.

Table VI-7c. Utilization of health center or clinic with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N %	30 (27)	5 (23)	10 (20)	15 (38)	14 (39)	2 (25)	5 (38)	7 (47)
Resource used without PCC involvement	N %	80 (73)	16 (76)	39 (80)	25 (62)	22 (61)	6 (75)	8 (62)	8 (53)
Base: all persons who have used health center or clinic	N %	110 (100)	21 (100)	49 (100)	40 (100)	36 (100)	8 (100)	13 (100)	15 (100)

Of the 146 respondents who have used the health clinic at some time, 44 or 30% of these persons state that they did so with PCC involvement. The proportion of long-time members reporting PCC assistance is highest in both the urban and rural subsamples. For many of the subjects who reported PCC involvement, this involvement most probably entailed enrollment in the medical facility with which the PCC has a liaison, affiliation or contract for service.

There is a significant difference across involvement in terms of use of this resource. A significantly greater number of less involved urban respondents reported use of a health clinic at T1 than was the case with more involved subjects. This difference between low and high-involved parents does not hold up in the T2 subsamples.

4.2.2. Public hospital

Table VI-8a. Knowledge and utilization of public hospital - urban.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	-	-	-	-	-	-	-	-
	%	-	-	-	-	-	-	-	-
Not available	N	2	-	-	2	2	-	-	2
	%	(1)	-	-	(4)	(1)	-	-	(4)
AWARENESS									
Available and not used	N	39	10	17	12	29	10	9	10
	%	(29)	(38)	(29)	(24)	(21)	(38)	(16)	(20)
Available and used	N	94	16	41	37	104	16	49	39
	%	(70)	(62)	(71)	(73)	(77)	(62)	(84)	(76)
Base:		135	26	58	51	135	26	58	51

Table VI-8b. Knowledge and utilization of public hospital - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/	N	1	-	-	1	3	-	2	1
unknown	%	(1)	-	-	(3)	(4)	-	(7)	(3)
Not available	N	23	4	6	13	8	1	1	6
	%	(31)	(29)	(21)	(39)	(11)	(7)	(4)	(18)
AWARENESS									
Available and	N	10	1	9	-	6	3	2	1
not used	%	(13)	(7)	(32)	-	(8)	(21)	(7)	(3)
Available and	N	41	9	13	19	58	10	23	25
used	%	(55)	(64)	(46)	(58)	(77)	(71)	(82)	(76)
Base		75	14	28	33	75	14	28	33

While not necessarily easily accessable, a public hospital is available to residents in all the study communities. Given this availability, it is surprising to find that at T1, 42% of the long-time rural members were unaware of the existence or availability of a public hospital. Although this proportion decreased at T2, it still remains the highest in this category (21%).

While the majority of respondents reported use of a public hospital at T1, the proportions reporting use increased significantly for the total sample at T2. The most striking increases in use occurred among short-time members as a whole. (The difference is significant at the .01 level). With the exception of new urban parents whose percentages remained stable from T1 to T2, all other categories of members increased in either their knowledge and/or use of this resource.

Judging from the data presented reflecting awareness and utilization of a health clinic and public hospital, it appears that respondents have, on the whole, substantial knowledge of available resources and are receiving services from these resources. The frequency and pattern of usage of these health resources will be presented in the next chapter.

Table VI-8c. Utilization of a public hospital with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N	5	1	-	4	1	-	1	-
	%	(5)	(6)	-	(10)	(2)	-	(3)	-
Resource used without PCC involvement	N	99	15	49	35	57	10	22	25
	%	(95)	(94)	(100)	(90)	(98)	(100)	(97)	(100)
Base: all persons who have used a public hospital	N	104	16	49	39	58	10	23	25
	%	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)

As can be seen from the data presented for utilization of a public hospital with PCC involvement, the overwhelming majority of respondents who have used this service did so on their own. This is not surprising as most women had children at the time they joined PCC and these children were, in most cases, delivered at the local public hospital. This may also account for the fact that no significant differences were found in terms of involvement for either knowledge or use of this resource.

4.2.3. Mental health clinic.

Table VI-9a. Knowledge and utilization of mental health clinic - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	45	10	19	16	28	4	17	7
	%	(33)	(38)	(33)	(31)	(21)	(15)	(29)	(14)
Not available	N	16	2	7	7	13	2	4	7
	%	(12)	(8)	(12)	(14)	(10)	(8)	(7)	(14)
AWARENESS									
Available and not used	N	64	13	30	21	82	18	35	29
	%	(47)	(50)	(52)	(41)	(61)	(69)	(60)	(57)
Available and used	N	10	1	2	7	12	2	2	8
	%	(7)	(4)	(3)	(14)	(9)	(8)	(3)	(16)
Base		135	26	58	51	135	26	58	51

Table VI-9b. Knowledge and utilization of mental health clinic-rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	25	7	7	11	15	2	7	6
	%	(33)	(50)	(25)	(33)	(20)	(14)	(25)	(18)
Not available	N	13	2	6	5	20	5	6	9
	%	(17)	(14)	(21)	(15)	(27)	(36)	(21)	(27)
AWARENESS									
Available and not used	N	31	5	10	16	26	4	10	12
	%	(41)	(36)	(36)	(48)	(35)	(29)	(36)	(36)
Available and used	N	6	-	5	1	14	3	5	6
	%	(8)	-	(18)	(3)	(19)	(21)	(18)	(18)
Base		75	14	28	33	75	14	28	33

A mental health clinic is unavailable in two of the rural communities. However, in one of these two communities there is a clinic 80 miles from the PCC and a staff member from this clinic does come to the PCC at times.

Awareness of mental health clinics increased from T1 to T2 among urban respondents. This is particularly true of new and long-time members. But, given the availability of a mental health clinic in all urban study sites, the percentages of those who don't know of the availability of such a resource are still rather high. In the rural subsample there occurred an appropriate decline in the number of persons reporting "don't know" and an increase in the number of "not available" responses. As the services of a mental health clinic are, at best, available with difficulty to a large percentage of the rural subsample, the increase in the number of "not available" responses may represent heightened awareness of the community's resources or lack of them.

The majority of the urban and rural parents who are aware of a mental health clinic's availability report that they have never used the resource. However, use did increase slightly in T2 for both subsamples, particularly among rural members. At T1, no new rural members reported use of this resource, whereas in T2, three of the new members stated that they had received service from the clinic.

Use of a mental health clinic presents an interesting case in that it requires a specific need and a certain degree of sophistication to recognize this need. Most often, recognition of need is made by trained personnel; most persons who have used a clinic have done so because of a referral. It is likely that referrals were made by PCC staff members or consultants.

Table VI-9c. Utilization of mental health clinic with PCC involvement.

RESPONSES		URBAN TOTAL	URBAN NEW	URBAN SHORT	URBAN LONG	RURAL TOTAL	RURAL NEW	RURAL SHORT	RURAL LONG
Resource used with PCC involvement	N %	4 (33)	1 (50)	- -	3 (38)	5 (36)	1 (33)	2 (40)	2 (33)
Resource used without PCC involvement	N %	8 (67)	1 (50)	2 (100)	5 (62)	9 (64)	2 (67)	3 (60)	4 (67)
Base: all persons who have used a mental health clinic	N %	12 (100)	2 (100)	2 (100)	8 (100)	14 (100)	3 (100)	5 (100)	6 (100)

The data for utilization of a mental health clinic with PCC involvement show that 35% of the 26 persons who have used this resource received some form of assistance from the PCC. While the majority of subjects who used this service did so on their own, the proportion of members reporting PCC involvement appears sizeable when the nature of the service is considered, the possible delicacy of the problem which makes referral necessary, and the social stigma that is often associated with receipt of this type of health care.

No significant differences were produced by the data related to respondents' level of involvement in PCC.

4.2.4. Family counseling agencies

Table VI-10a. Knowledge and utilization of family counseling agencies - urban.

		TIME 1 *(1)				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG**(1)	TOTAL	NEW	SHORT	LONG**(1)
NON-AWARENESS									
Don't know/ unknown	N	36	4	12	20	35	7	16	12
	%	(27)	(15)	(21)	(39)	(26)	(27)	(28)	(24)
Not available	N	21	5	7	9	11	3	5	3
	%	(16)	(19)	(12)	(18)	(8)	(12)	(9)	(6)
AWARENESS									
Available and not used	N	70	15	35	20	72	14	31	27
	%	(52)	(58)	(60)	(39)	(53)	(54)	(53)	(53)
Available and used	N	8	2	4	2	17	2	6	9
	%	(6)	(8)	(7)	(4)	(13)	(8)	(10)	(18)
Base		135	26	58	51	135	26	58	51

**(1) Chi-square significant at .01 level for knowledge of resource

*(1) Chi-square significant at .05 level for knowledge of resource

Table VI-10b. Knowledge and utilization of family counseling agencies - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/	N	25	6	10	9	23	4	9	10
unknown	%	(33)	(43)	(36)	(27)	(31)	(29)	(32)	(30)
Not available	N	22	6	6	10	17	4	3	10
	%	(29)	(43)	(21)	(30)	(23)	(29)	(11)	(30)
AWARENESS									
Available and	N	21	2	8	11	22	3	11	8
not used	%	(28)	(14)	(29)	(33)	(29)	(21)	(39)	(24)
Available and	N	7	-	4	3	13	3	5	5
used	%	(9)	-	(14)	(9)	(17)	(21)	(18)	(15)
Base		75	14	28	33	75	14	28	33

Family counseling agencies represent a resource not apt to be widely used by respondents as it is used when a specific problem arises, and requires considerable sophistication for use. A family counseling agency is available in all urban areas and in two of the three rural areas.

Lack of knowledge of the resource decreased over time: however, 34% of the urban subsample and 54% of the rural subsample did not know of the resource or thought it was unavailable at T2. The higher proportion of rural respondents in this category is expected as one rural community does not have such a resource. However, in T2, 31% of the rural subsample still replied, "don't know". The increase in awareness of resource was significant among long-term urban members (43% were aware of resource at T1, and 71% at T2) and marked among new rural members (14% at T1 and 42% at T2). These two subgroups also had the highest incidences of actual use as reported in T2. While long-time urban subjects increased their awareness of the resource across time, at T1, this subgroup was significantly less knowledgeable about a family counseling agency than were either new or short-time urban members.

In the urban subsample, while a majority of the respondents were aware of the resource at both T1 and T2, over 50% of this subsample reported that they had never used such an agency. The pattern in the rural subsample was similar. Although fewer rural respondents knew of the resource's availability than was true of the urban subjects, the majority of those who were knowledgeable about the service also reported non-use. Thus, the percentages for use of family counseling agencies are low. However, even given the small cell _N_s, some interesting patterns emerge. Receipt of family counseling services more than doubled among urban respondents from T1 to T2. Within this subsample, use by long-time members increased four and one-half times during the evaluation period. The increase in use among rural respondents was almost as great as that for urbans (9% in T1, 17% in T2). Of interest here are the new rural parents. At T1 there were no new parents reporting use while at T2, 21% of the 14 new members stated that the service was available and used. Gains in use were also reported by all other groups with the exception of urban new members whose percentages remained stable over time.

Table VI-10c. Utilization of family counseling agencies with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N %	8 (47)	- -	1 (17)	7 (78)	3 (23)	1 (33)	1 (20)	1 (20)
Resource used without PCC involvement	N %	9 (53)	2 (100)	5 (83)	2 (22)	10 (77)	2 (67)	4 (80)	4 (80)
Base: all persons who have used resource	N %	17 (100)	2 (100)	6 (100)	9 (100)	13 (100)	3 (100)	5 (100)	5 (100)

Over one-third of the 30 respondents who reported use of a family counseling agency also reported PCC involvement in their use. The two groups which reported the highest frequencies of use, new rural and long-time urban members had the highest percentages for PCC involvement as well. Seventy-eight percent of the nine long-time urban respondents who have used this agency did so with help from the PCC.

A significant difference in terms of use of resource occurred at T2 between urban high and low involved respondents. Among this subsample, less involved members were the greater users of the service than were more highly involved members. This was the only significant difference for this item along involvement.

4.2.5. Planned parenthood services

Table VI-11a. Knowledge and utilization of planned parenthood services - urban.

RESPONSES		TIME 1*				TIME 2			
		TOTAL*(1)	NEW	SHORT	LONG*(1) *(2)	TOTAL*(1)	NEW	SHORT	LONG*(1) *(2)
NON-AWARENESS									
Don't know/ unknown	N	18	4	6	8	6	-	6	-
	%	(13)	(15)	(10)	(16)	(4)	-	(10)	-
Not available	N	5	1	-	4	4	-	-	4
	%	(4)	(4)	-	(8)	(3)	-	-	(8)
AWARENESS									
Available & not used	N	57	12	20	25	50	12	18	20
	%	(42)	(46)	(34)	(49)	(37)	(46)	(31)	(39)
Available & used	N	55	9	32	14	75	14	34	27
	%	(41)	(35)	(55)	(27)	(56)	(54)	(59)	(53)
Base		135	26	58	51	135	26	58	51

*(1) Chi-square significant at .05 level for knowledge of resource.
*(2) Chi-square significant at .05 level for use of resource.

Table VI-11b. Knowledge and utilization of planned parenthood services - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL**(1)	NEW	SHORT	LONG	TOTAL**(1)	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	14	4	3	7	7	1	1	5
	%	(19)	(29)	(11)	(21)	(9)	(7)	(4)	(15)
Not available	N	16	3	4	9	5	-	1	4
	%	(21)	(21)	(14)	(27)	(7)	-	(4)	(12)
AWARENESS									
Available & not used	N	29	6	13	10	30	9	12	9
	%	(39)	(43)	(46)	(30)	(40)	(64)	(43)	(27)
Available and used	N	16	1	8	7	33	4	14	15
	%	(21)	(7)	(29)	(21)	(44)	(29)	(50)	(45)
Base		75	14	28	33	75	14	28	33

**(1) Chi-square significant at .01 level for knowledge of resource.

The health components at several PCCs have made extensive efforts to disseminate information concerning family planning. Attempts have been made to inform parents both of contraceptive methods and of agencies that provide related services.

This is one area in which PCC has had a striking impact. Among all respondents, both knowledge and use of resource increased significantly; knowledge of the service increased 15 percentage points from T1 to T2, and actual use rose by 17 percentage points (both significant at the $P<.05$ level).

This pattern remains stable when the sample is divided by locale and longevity of membership. Significant increases in awareness of resource occurred in both the urban and rural subsamples. At T1, 40% of the rural subjects either did not know of the service or thought it unavailable, compared to 17% of the urban subsample. Within the rural subsample, 50% of the new members and 48% of the long-time members were in this category. At T2, a marked decrease occurred: 16% of the rural members and only 7% of the urban members did not know of the service or its availability. While lack of knowledge at T2 is still fairly high among long-time rural members (27%), the decrease from T1 (48%) is encouraging. The decrease in lack of knowledge among urban long-time members is significant.

At T1, most respondents who were aware of existing family planning services reported that they did not use the resource. The pattern is reversed at T2; the majority of the people who are knowledgeable about the resource also report use.

At both T1 and T2, the proportion of members who have used planned parenthood services is greater among urban than among rural subjects. Use increased 10 percentage points from T1 to T2 among the urban subsample and more than doubled among rural respondents. With the exception of new and long-time rural subjects the T2 data for every other category of member show that at least 50% of each group has used planned parenthood services. While the percentages at T2 for new and long-time rural respondents are 29% and 45% respectively, these represent increases over T1 of 22 and 24 percentage points; use among long-time members more than doubled and use among new members more than quadrupled. Use among long-time urban members increased significantly at T2. At T1, significantly fewer people in this subgroup used the resource than did new or short-time urban members.

Table VI-11c. Utilization of planned parenthood services with PCC involvement.

	URBAN				RURAL			
RESPONSES	TOTAL***	NEW	SHORT	LONG	TOTAL***	NEW	SHORT	LONG
Resource used with PCC involvement	15 (20)	2 (14)	7 (21)	6 (22)	21 (64)	2 (50)	9 (64)	10 (66)
Resource used without PCC involvement	60 (80)	12 (86)	27 (79)	21 (78)	12 (36)	2 (50)	5 (36)	5 (34)
Base: persons who have used the resource	75 (100)	14 (100)	34 (100)	27 (100)	33 (100)	4 (100)	14 (100)	15 (100)

*** Chi-square significant at .001 level for use of resource with PCC involvement.

The PCC was involved in one-third of the 108 cases in which use of planned parenthood services was reported. PCC involvement was more than three times as great for rural than for urban respondents, a highly significant difference. This is as expected, considering the high percentage of rural respondents who were unaware of the service and the low percentage of respondents who used the service at T1.

Among rural respondents at T2, a significant difference in terms of use across involvement occurred. The proportion of highly involved members reporting use of planned parenthood services was significantly greater than that of less involved members. Chi-square analyses performed on other involvement data showed no significant differences.

4.3 Early childhood programs

4.3.1 Head Start

Table VI-12a. Knowledge and utilization of Head Start - urban***(2)

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	8	2	6	-	6	2	3	1
	%	(6)	(8)	(10)	-	(4)	(8)	(5)	(2)
Not available	N	2	-	2	-	10	3	5	2
	%	(1)	-	(3)	-	(7)	(12)	(9)	(4)
AWARENESS									
Available and not used	N	72	18	35	19	69	15	37	17
	%	(53)	(69)	(60)	(37)	(51)	(58)	(64)	(33)
Available and used	N	53	6	15	32	50	6	13	31
	%	(39)	(23)	(26)	(63)	(37)	(23)	(22)	(61)
Base		135	26	58	51	135	26	58	51

***(2) Chi-square significant at .001 level for use of resource

Table VI-12b. Knowledge and utilization of Head Start - rural.

		TIME 1				TIME 2*(2)			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/	N	5	4	1	-	1	1	-	-
unknown	%	(7)	(29)	(4)	-	(1)	(7)	-	-
Not avail-	N	11	-	7	4	7	-	3	4
able	%	(15)	-	(25)	(12)	(9)	-	(11)	(12)
AWARENESS									
Available and	N	24	6	9	9	23	6	12	5
not used	%	(32)	(43)	(32)	(27)	(31)	(43)	(43)	(15)
Available and	N	35	4	11	20	44	7	13	24
used	%	(47)	(29)	(39)	(61)	(59)	(50)	(46)	(73)
Base		75	14	28	33	75	14	28	33

*(2)Chi-square significant at .05 level for use of resource.

At T2 a Head Start Program is not available to residents of one urban community. In both the urban and rural subsamples, knowledge of Head Start was greatest among long-time members. At T1, use was significantly greater among long-time urban members than was true of short-time or new members. At T2, this significant difference occurred in both subsamples. It might be expected that use of this resource would be greatest among these respondents, who generally have larger and hence older families; they are more likely to have a Head Start eligible child. While use at T2 by urban members decreased slightly for reasons previously mentioned, use among the rural subsample increased by 12 percentage points.

It is interesting that while such a large percentage of all PCC parents (45% at T2) use this resource, only a small percentage of parents (8%) serve on Head Start Policy Councils.

Table VI-12c. Utilization of Head Start with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL**	NEW	SHORT	LONG	TOTAL**	NEW	SHORT	LONG
Resource used with PCC involvement	N	21	1	7	13	33	5	10	18
	%	(42)	(16)	(54)	(42)	(75)	(71)	(77)	(75)
Resource used without PCC involvement	N	29	5	6	18	11	2	3	6
	%	(58)	(84)	(46)	(58)	(25)	(29)	(23)	(25)
Base: all persons who have used Head Start	N	50	6	13	31	44	7	13	24
	%	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)

** Chi-square significant at .01 level for use of resource with PCC involvement.

The percentage of respondents reporting that their children were enrolled in Head Start as a result of PCC efforts is quite high. Fifty-four (57%) of the ninety-four persons who have used Head Start did so with some form of PCC assistance. Significantly more PCC assistance was given to rural than to urban members. The overwhelming majority of rural respondents (75%) using this resource report PCC assistance while only 42% of the urban members report such assistance.

Level of parental involvement in PCC did not significantly effect subjects' knowledge or use of Head Start.

4.3.2. Day care or child care programs.

Table VI-13a. Knowledge and utilization of day care or child care programs - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/	N	12	4	4	4	4	2	-	2
unknown	%	(9)	(15)	(7)	(8)	(3)	(7)	-	(4)
Not available	N	4	1	1	2	11	3	5	3
	%	(3)	(4)	(2)	(4)	(8)	(12)	(9)	(6)
AWARENESS									
Available and	N	77	15	31	31	66	13	29	24
not used	%	(57)	(58)	(53)	(61)	(49)	(50)	(50)	(47)
Available and	N	42	6	22	14	54	8	24	22
used	%	(31)	(23)	(38)	(27)	(40)	(31)	(41)	(43)
Base		135	26	58	51	135	26	58	51

Table VI-13b. Knowledge and utilization of day care or child care programs - rural.

		TIME 1 *(1)				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/	N	9	3	3	3	4	-	1	3
unknown	%	(12)	(21)	(4)	(9)	(5)	-	(4)	(9)
Not available	N	14	4	1	9	15	5	3	7
	%	(19)	(29)	(11)	(27)	(20)	(36)	(11)	(21)
AWARENESS									
Available and	N	35	5	17	13	41	9	16	16
not used	%	(47)	(36)	(61)	(39)	(55)	(64)	(57)	(48)
Available and	N	17	2	7	8	15	-	8	7
used	%	(23)	(14)	(25)	(24)	(20)	-	(29)	(21)
Base		75	14	28	33	75	14	28	33

*(1) Chi-square significant at .05 level for knowledge of resource

At both T1 and T2, knowledge and utilization of this resource is far greater among urban than among rural respondents. While both awareness and use increased slightly in T2, the majority of people who know of the service's availability report that they do not use the resource. Although awareness of this resource did increase across time, at T2 there still remained one quarter of the rural subsample who reported that they either did not know of a day care or child care program or that such a program was not available. At T1, a significantly greater proportion of short-time rural members were aware of this resource than was the case with new and long-time members. This difference was not maintained at T2 due to the increased knowledgeability gained by both new and long-time subjects.

Table VI-13c. Utilization of day care or child care programs with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL**	NEW	SHORT	LONG	TOTAL**	NEW	SHORT	LONG
Resource used with PCC involvement	N	35	5	16	14	3	-	1	2
	%	(65)	(63)	(67)	(64)	(20)	-	(23)	(29)
Resource used without PCC involvement	N	19	3	8	8	12	-	7	5
	%	(35)	(37)	(33)	(36)	(80)	-	(87)	(71)
Base: all persons who have used this resource	N	54	8	24	22	15	-	8	7
	%	(100)	(100)	(100)	(100)	(100)	-	(100)	(100)

**Chi-square significant at .01 level for use of resource with PCC involvement.

Of the 69 parents reporting use of a day care or child care program, 38 or 55% of this group state that they did so with PCC assistance. While use of this resource was highest among urban parents, so was PCC involvement. A significantly greater proportion of urban parents report receipt of PCC assistance than do rural respondents.

In terms of involvement, among rural respondents at T1, a significantly greater number of highly involved PCC participants report use of this type of program than do less involved members. No other involvement comparisons were significant.

4.4 Free legal services (Legal Aid)

Table VI-14a. Knowledge and utilization of free legal services - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	21	3	11	7	15	3	6	6
	%	(16)	(12)	(19)	(14)	(11)	(12)	(10)	(12)
Not available	N	9	1	2	6	8	-	6	2
	%	(7)	(4)	(3)	(12)	(6)	-	(10)	(4)
AWARENESS									
Available and not used	N	75	16	35	24	73	18	32	23
	%	(56)	(62)	(60)	(47)	(54)	(69)	(55)	(45)
Available and used	N	30	6	10	14	39	5	14	20
	%	(22)	(23)	(17)	(27)	(29)	(19)	(24)	(39)
Base		135	26	58	51	135	26	58	51

Table VI-14b. Knowledge and utilization of free legal services - rural.

		TIME 1 *(1)				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	19	6	5	8	19	5	3	11
	%	(25)	(43)	(18)	(24)	(25)	(36)	(11)	(33)
Not available	N	29	5	7	17	27	3	11	13
	%	(39)	(36)	(25)	(51)	(36)	(21)	(39)	(39)
AWARENESS									
Available and not used	N	15	1	9	5	21	6	11	4
	%	(20)	(7)	(32)	(15)	(28)	(43)	(39)	(12)
Available and used	N	12	2	7	3	8	-	3	5
	%	(16)	(14)	(25)	(9)	(11)	-	(11)	(15)
Base		75	14	28	33	75	14	28	33

*(1)Chi-square significant at .05 level for knowledge of resource.

Free legal services are not readily available to residents of one rural community. While there is an appointed attorney to handle legal aid - type cases, his caseload is such as to prohibit his serving all persons who might have need for legal counsel.

As use of legal aid is dependent upon specific need, a more important measure than use is knowledge of the resource. At both T1 and T2, the percentage of urban respondents who report awareness of this resource is significantly greater than is the percentage of rural respondents in the same category. While knowledge of the resource increased 18 percentage points from T1 to T2 in the rural subsample, at T2 there still remained

25% of the rural respondents who replied "don't know or unknown." At T1, knowledge of this resource was significantly greater among short-time rural respondents than among new or long-time members of this subsample.

Table VI-14c. Utilization of free legal services with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N	13	2	1	10	2	-	1	1
	%	(33)	(40)	(7)	(50)	(25)	-	(33)	(20)
Resource used without PCC involvement	N	26	3	13	10	6	-	2	4
	%	(67)	(60)	(93)	(50)	(75)	-	(67)	(80)
Base: all persons who have used resource	N	39	5	14	20	8	-	3	5
	%	(100)	(100)	(100)	(100)	(100)	-	(100)	(100)

Approximately one-third of the respondents who report use of free legal services also report PCC involvement in this use. The frequency of these reports is greatest among urban subjects, for whom use is greatest as well. At one urban PCC, a representative from Legal Aid makes periodic visits to help participants with problems primarily related to immigration. This may, in part, account for the larger proportion of urban respondents reporting use of this resource with PCC involvement.

No significant differences were produced by comparisons of the involvement data.

4.5 Housing Authority

Table VI-15a. Knowledge and utilization of housing authority - urban.

		TIME 1 *(2)				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/	N	11	2	4	5	9	3	2	4
unknown	%	(8)	(8)	(7)	(10)	(7)	(12)	(3)	(8)
Not avail-	N	3	1	1	1	6	-	4	2
able	%	(2)	(4)	(2)	(2)	(4)	-	(7)	(4)
AWARENESS									
Available and	N	73	14	39	20	71	12	37	22
not used	%	(54)	(54)	(67)	(39)	(53)	(46)	(64)	(43)
Available and	N	48	9	14	25	49	11	15	23
used	%	(36)	(35)	(24)	(49)	(36)	(43)	(26)	(45)
Base		135	26	58	51	135	26	58	51

*(2)Chi-square significant at .05 level for use of resource.

Table VI-15b. Knowledge and utilization of housing authority - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/	N	21	7	9	5	18	3	6	9
unknown	%	(28)	(50)	(32)	(15)	(24)	(21)	(21)	(27)
Not avail-	N	34	6	11	17	28	5	11	12
able	%	(45)	(43)	(39)	(51)	(37)	(36)	(39)	(36)
AWARENESS									
Available and	N	18	1	7	10	26	6	11	9
not used	%	(24)	(7)	(25)	(30)	(35)	(43)	(39)	(27)
Available and	N	2	-	1	1	3	-	-	3
used	%	(3)	-	(4)	(3)	(4)	-	-	(9)
Base		75	14	28	33	75	14	28	33

Although a housing authority is a resource available to all study PCC communities, the majority of the rural respondents are unaware of such an agency, or report erroneously that it is unavailable; approximately 10% of the urban subjects give the same report. This is not a surprising statistic as most rural families live in single family dwellings and are most likely to report their housing problems to their landlords, if anyone. On the other hand, many urban families live in apartment buildings, some of which are publicly subsidized and might therefore have more ready access to a public agency, the housing authority.

Over one-third of the urban members report that they have, at some time, contacted the housing authority. At T1, significantly more long-term urban members reported use than did new or short-time members. At T2, this difference in use almost reaches statistical significance.

Table VI-15c. Utilization of housing authority with PCC involvement.

		URBAN				RURAL			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N	4	2	2	-	-	-	-	-
	%	(8)	(18)	(13)	-	-	-	-	-
Resource used without PCC involvement	N	45	9	13	23	3	-	-	3
	%	(92)	(82)	(87)	(100)	(100)	-	-	(100)
Base: all persons who have used resource	N	49	11	15	23	3	-	-	3
	%	(100)	(100)	(100)	(100)	(100)	-	-	(100)

Of the 52 persons who reported contact with the housing authority, only 4 or 8% of these subjects report that they did so with PCC involvement. The three rural respondents who had used the resource did not recall that the PCC was in any way involved.

Data for awareness or use of resource as it relates to level of participation in PCC produced no significant differences.

4.6 Resources related to employment.

4.6.1 State employment office.

Table VI-16a. Knowledge and utilization of state employment office-urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	7	3	1	3	5	2	3	-
	%	(5)	(12)	(2)	(6)	(4)	(8)	(5)	-
Not available	N	2	1	-	1	5	2	1	2
	%	(1)	(4)	-	(2)	(4)	(8)	(1)	(4)
AWARENESS									
Available and not used	N	68	10	34	24	71	11	29	31
	%	(50)	(38)	(59)	(47)	(52)	(42)	(50)	(61)
Available and used	N	58	12	23	23	54	11	25	18
	%	(43)	(46)	(40)	(45)	(40)	(42)	(43)	(35)
Base		135	26	58	51	135	26	58	51

Table VI-16b. Knowledge and utilization of state employment office - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL**(1)	NEW	SHORT	LONG	TOTAL**(1)	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	13	4	3	6	6	–	4	2
	%	(17)	(29)	(11)	(18)	(8)	–	(14)	(6)
Not available	N	18	2	8	8	8	2	1	5
	%	(24)	(14)	(29)	(24)	(11)	(14)	(4)	(15)
AWARENESS									
Available and not used	N	29	4	14	11	33	9	9	15
	%	(39)	(29)	(50)	(33)	(49)	(64)	(32)	(45)
Available and used	N	15	4	3	8	28	3	14	11
	%	(20)	(29)	(11)	(24)	(37)	(21)	(50)	(33)
Base		75	14	28	33	75	14	28	33

**(1)Chi-square significant at .01 level for knowledge of resource.

Each PCC catchment area is served by a state employment office, however, at one rural PCC, this office is approximately 70 miles from the Center, making it available only with difficulty.

Awareness of the resource is far lower among rural than urban respondents. While rural respondents were almost twice as knowledgeable about this service at T2 (a significant difference), there still remained almost one-fifth (19%) of the sample who reported the office to be either "unknown" or "not available" to them. These responses may be attributable to subjects living 70 miles from the nearest state employment office. In the urban subsample, the percentage of respondents familiar with this agency is almost as high as it is for such services as welfare and medicaid, two of the most widely known services.

Table VI-16c. Utilization of state employment office with PCC involvement.

RESPONSES		URBAN TOTAL	URBAN NEW	URBAN SHORT	URBAN LONG	RURAL TOTAL	RURAL NEW	RURAL SHORT	RURAL LONG
Resource used with PCC involvement	N %	2 (4)	- -	1 (4)	1 (6)	- -	- -	- -	- -
Resource used without PCC involvement	N %	52 (96)	11 (100)	24 (96)	17 (94)	28 (100)	3 (100)	14 (100)	11 (100)
Base: all persons who have used resource	N %	54 (100)	11 (100)	25 (100)	18 (100)	28 (100)	3 (100)	14 (100)	11 (100)

It is expected that the state employment office would be a prime resource contacted for referrals by the PCC. This may still be true; however, it seems that this is a resource heavily used, particularly among urban respondents, regardless of PCC. The data presented for utilization of a state employment office support this idea. Of the 82 persons who have used this resource at some time, only two (or 2%) report having done so as a result of PCC involvement.

Data for high and low involved subjects yielded no significant differences.

4.6.2. Job training program.

Table VI-17a. Knowledge and utilization of job training programs - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	15	3	6	6	13	3	7	3
	%	(11)	(12)	(10)	(12)	(10)	(12)	(12)	(6)
Not available	N	4	2	1	1	6	1	4	1
	%	(3)	(8)	(2)	(2)	(4)	(4)	(7)	(2)
AWARENESS									
Available and not used	N	72	10	35	27	78	14	28	36
	%	(53)	(38)	(60)	(53)	(58)	(54)	(48)	(71)
Available and used	N	44	11	16	17	38	8	19	11
	%	(33)	(42)	(28)	(33)	(28)	(31)	(33)	(22)
Base		135	26	58	51	135	26	58	51

Table VI-17b. Knowledge and utilization of job training programs - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
NON-AWARENESS									
Don't know/ unknown	N	21	5	6	10	15	2	5	8
	%	(28)	(36)	(21)	(30)	(20)	(14)	(18)	(24)
Not available	N	9	3	4	2	14	4	3	7
	%	(12)	(21)	(14)	(6)	(19)	(29)	(11)	(21)
AWARENESS									
Available and not used	N	36	5	13	18	37	7	16	14
	%	(48)	(36)	(46)	(54)	(49)	(50)	(57)	(42)
Available and used	N	9	1	5	3	9	1	4	4
	%	(12)	(7)	(18)	(9)	(12)	(7)	(14)	(12)
Base		75	14	28	33	75	14	28	33

Overall, in both T1 and T2, proportionately more urban than rural respondents are aware of the availability of this resource and, in turn, more than twice as many urban (30%) as rural (12%) parents report contact with a job training program. As with a state employment office, in the urban sample, new parents represent a high proportion of those persons who report having used this resource.

In the rural subsample, new parents are the least knowledgeable about the resource, although at T2, 45% of the long-time members were also unaware of such a program's availability. For both subsamples, knowledge and use of resource remained fairly stable throughout the interviewing time span.

Table VI-17c. Utilization of job training program with PCC involvement.

RESPONSES		URBAN				RURAL			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Resource used with PCC involvement	N %	5 (13)	1 (13)	3 (16)	1 (9)	- -	- -	- -	- -
Resource used without PCC involvement	N %	33 (87)	7 (87)	16 (84)	10 (91)	9 (100)	1 (100)	4 (100)	4 (100)
Base: all persons who have used resource	N %	38 (100)	8 (100)	19 (100)	11 (100)	9 (100)	1 (100)	4 (100)	4 (100)

Ten percent, or 5 of the 47 respondents who participated in a job training program, report that they did so as an outcome of a PCC referral or other assistance. All persons in this category are members of urban PCCs.

Level of PCC participant involvement did not effect subjects' knowledge or use of job training programs.

5.0 Summary

MEMBERSHIP IN COMMUNITY GROUPS

- Regardless of length of membership in PCC or involvement level, the majority of respondents do not belong to any community groups or organizations. No subgroup significantly increased their involvement in community groups or on community boards during the course of the program year.
- Although the percentages are small, at both T1 and T2, the largest proportion of respondents report membership in such organizarions as church-related groups, block associations, veterans' groups, bowling leagues, etc.

ENROLLMENT IN COURSE WORK

- The majority of parents are not enrolled in any type of education program.
- No subgroups significantly increased their enrollment in course work during the evaluation year.

are members of urban PCCs.

Level of PCC participant involvement did not effect subjects' knowledge or use of job training programs.

5.0 Summary

MEMBERSHIP IN COMMUNITY GROUPS

- Regardless of length of membership in PCC or involvement level, the majority of respondents do not belong to any community groups or organizations. No subgroup significantly increased their involvement in community groups or on community boards during the course of the program year.

- Although the percentages are small, at both T1 and T2, the largest proportion of respondents report membership in such organizarions as church-related groups, block associations, veterans' groups, bowling leagues, etc.

ENROLLMENT IN COURSE WORK

- The majority of parents are not enrolled in any type of education program.

- No subgroups significantly increased their enrollment in course work during the evaluation year.

- Of the 52 urban and rural respondents enrolled in course work at T2, 21 (40%) report that they did so with PCC involvement.

BASIC SUPPORTIVE SERVICES

- Food stamps have been used by the majority of respondents.
- The proportion of respondents receiving food stamps remained relatively stable over time.
- Fourteen percent of the persons who received food stamps reported that they did so with assistance from PCC.
- No subgroup increased significantly in terms of knowledge or use of commodities during the program year.
- Of the sixty-two respondents who reported use of commodities at some time, approximately one-quarter report PCC assistance in obtaining benefits.
- Medicaid is among the most widely known and used resources.
- It appears that knowledge and use of medicaid is more a function of use of public assistance than of length of membership or involvement in PCC. No subgroup increased significantly in either their awareness or use of medicaid during the course of the program year.

- Eighty-seven percent of the 136 persons receiving medicaid report obtaining benefits without PCC assistance.
- Over 60% of the total sample has used welfare at some time.
- No subgroup increased significantly in terms of knowledge or use of welfare during the evaluation period.
- Only 9% of the 128 persons who have used welfare report PCC aid.

MEDICAL FACILITIES

- Thirty percent of the respondents who have used a health clinic at some time report that they did so with PCC assistance.
- The proportion of respondents reporting use of a public hospital increased significantly for the total sample from T1 to T2.
- The overwhelming majority (96%) of the 162 respondents who have used a public hospital report having done so without PCC assistance.
- The majority of the urban and rural parents who are aware of a mental health clinic's availability report that they have never used the resource.
- Thirty-five percent of the 26 persons who have used a mental health clinic received some form of assistance from the PCC.

- No subgroup significantly increased its knowledge or use of a mental health clinic during the course of the program year.

- The majority of the respondents who were aware of a family counseling agency's availability also reported non-use of this resource.

- Over one-third of the 30 respondents who reported use of a family counseling agency also reported PCC involvement in their use.

- For both the urban and rural subsamples, knowledge and use of planned parenthood services increased significantly from T1 to T2.

- Knowledge of planned parenthood services significantly increased among long-term urban members during the course of the program year. Use of the resource also increased significantly over time for this subgroup. The PCC was involved in one-third of the 108 cases in which use of planned parenthood services was reported. PCC involvement was significantly greater for rural than for urban respondents.

- At T2, significantly more highly involved rural members reported use of planned parenthood services than was true of low involved rural members.

EARLY CHILDHOOD PROGRAMS

- The overwhelming majority of respondents are aware of the Head Start program.
- At T1, use of a Head Start program was significantly greater among long-time urban members than among new or short-time members. At T2, this significant difference occurred in both subsamples.
- Fifty-four (57%) of the ninety-four persons who have used Head Start did so with some form of PCC involvement. More PCC assistance was given to rural than to urban members.
- Of the 69 parents reporting use of a day care or child care program, 38 or 55% of this group report that they did so with PCC assistance. PCC aid was significantly greater for urban than for rural respondents.

RESOURCES RELATED TO EMPLOYMENT

- Knowledge of a state employment office increased significantly from T1 to T2 among rural respondents. However, urban members were more aware of this resource than were their rural counterparts.
- Of the 82 persons who report having used a state employment office, only 2 report having done so as a result of PCC involvement.

- Proportionately more urban than rural respondents are aware of the availability of job training programs and, in turn, twice as many urban than rural parents report contact with this resource.

- Ten percent of the 47 respondents who participated in a job training program, report that they did so as an outcome of PCC assistance.

CHAPTER VII

HEALTH AND NUTRITION

1.0 Overview

Improving the health of member families has always been a priority objective of PCC. At most PCCs this means a facilitator role for the PCC which establishes a relationship with a health facility to ensure receipt of services. In most such instances, the family is enrolled at the health service with the assistance of PCC; where the PCC has a nurse, she acts as liason between PCC and the health agency. The nurse reminds families of scheduled appointments, keeps records, and makes sure that the doctor's recommendations are understood and followed. At PCCs located in rural areas, there is a dearth of health care, so that certain services such as immunizations are provided on-site by the PCC nurse. At other rural PCCs, the program purchases services for any family which cannot afford medical care. Health education and nutrition education are part of the overall emphasis on health of every PCC program. In some programs, both topics are taught by the nurse, in some there is a separate nurse and nutritionist, and in still others, one or both are taught by the parent educator along with many other topics. As described in Chapter I, the Centers represented within the present study reflect the diversity of PCC approaches to health and nutrition.

2.0 Health care

2.1 Pre-natal care

Table VII-1a. Number of pre-natal visits - urban.

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
None	5 (4)	1 (4)	3 (5)	1 (2)	2 (1)	- -	1 (2)	1 (2)
1-2 visits	5 (4)	2 (7)	2 (3)	1 (2)	1 (*)	1 (4)	- -	- -
3-5 visits	7 (5)	2 (7)	4 (7)	1 (2)	14 (10)	1 (4)	10 (17)	3 (6)
6-9 visits	30 (22)	1 (4)	19 (33)	10 (20)	42 (31)	9 (35)	18 (31)	15 (29)
10 or more	88 (65)	20 (77)	30 (52)	38 (75)	76 (56)	15 (57)	29 (50)	32 (63)
Base	135	26	58	51	135	26	58	51

(*) less than 1%

Table VII-1b. Number of pre-natal visits - rural.

	TIME 1				TIME 2			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
None	2 (3)	- -	- -	2 (6)	4 (5)	1 (7)	2 (7)	1 (3)
1-2 visits	1 (1)	- -	1 (3)	- -	3 (4)	- -	2 (7)	1 (3)
3-5 visits	8 (11)	1 (7)	2 (7)	5 (15)	9 (12)	1 (7)	2 (7)	6 (18)
6-9 visits	36 (48)	4 (29)	17 (61)	15 (45)	29 (39)	4 (29)	10 (36)	15 (45)
10 or more	28 (37)	9 (64)	8 (29)	11 (33)	30 (40)	8 (57)	12 (43)	10 (30)
Base	75	14	28	33	75	14	28	33

(*) less than 1%

Table VII-1c. Trimester during which pre-natal care began.

	TIME 1				TIME 2			
	URBAN				RURAL			
RESPONSES	TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
1st trimester	87 (64)	19 (73)	31 (53)	37 (73)	42 (56)	10 (71)	15 (54)	17 (52)
2nd trimester	38 (28)	5 (19)	22 (38)	11 (21)	26 (35)	2 (14)	11 (39)	13 (39)
3rd trimester	8 (6)	2 (8)	4 (7)	2 (4)	3 (4)	1 (7)	- -	2 (6)
No pre-natal care	2 (1)	- -	1 (2)	1 (2)	4 (5)	1 (7)	2 (7)	1 (3)
Base	135	26	58	51	75	14	28	33

The data presented in these tables are reports (at T1 and T2) of respondents' behavior during their last pregnancy. While 43% (or 91) of the subjects reported that they had had a child since joining PCC, the data represent reports from all respondents.

At T1, it had been predicted that mothers who became pregnant while they were PCC members (ongoing mothers) would have had more pre-natal visits than mothers who had babies outside of the PCC sphere of influence (new mothers). At both T1 and T2, at least one-half of the respondents reported that they had had ten or more pre-natal visits. Particularly in T1, the largest proportion of such responses occurred among new parents. While the majority of new and ongoing members had 10 or more pre-natal visits, the vast majority of both groups had at least six or more visits.

These data suggest that pre-natal care is a service sought out by expectant mothers regardless of PCC membership or influence.

When the data are broken down more specifically by locale and longevity, the trends remain consistent. At T1, both urban and rural new members showed the highest percentages for 10 or more visits. At T2, where there was a decrease in the number of urban respondents in this category, new members are still highly represented. While short-time members report low percentages for 10 or more visits, the overwhelming majority of this group have had at least six visits.

The proportion of respondents receiving no pre-natal care is low. However, when the number of mothers reporting no pre-natal care are added to the number who had only one or two pre-natal visits, it can be seen that 9% of the rural respondents are in this category at T2. Six women who had babies since joining PCC can be characterized as having had insufficient pre-natal care.

While reporting the number of pre-natal care visits received during pregnancy does give some measure of the extent of care, a more important measure is the trimester during which pre-natal care began. The possibility exists that a woman could have had five or six pre-natal visits all during her last two months of pregnancy. As is well known, the most effective and safest form of pre-natal care is care received early in the pregnancy so that any possible problems can be detected and treated appropriately.

At T2 interviews, respondents were asked to provide information on the trimester during which pre-natal care began. Although interviewers stressed that they were interested in the time at which ongoing care began, it seems possible (when comparing number of visits vis-a-vis trimester data) that a small number of respondents reported the time at which they went to the doctor to verify their pregnancy. While this possible error should be noted, comparison of data show that the proportion of such responses is not large enough to seriously affect the trends in the data presented.

Over ninety percent of the sample report receiving pre-natal care no later than during their second trimester of pregnancy. Within this group, twice as many persons state that care began in the first trimester. These figures seem consistent with those for number of visits. Once again, when the data for first and second trimesters are combined, the differences across longevity are not marked.

Only five percent of the respondents report waiting until their third trimester of pregnancy to begin pre-natal care.

2.2 Immunizations

Ensuring that all children are immunized, appropriate to their age, has been a priority PCC objective. To achieve this objective, some PCCs arrange to have a nurse give immunizations at the Center, others provide transportation to a clinic or doctor, while still other PCCs make appointments at the health facility for their participants. Whatever the method, every PCC tries to have all children immunized at the proper time in their development.

Table VII-2a. DPT: immunization of all children 4 years or younger - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Fully immunized appropriate for age	N	210	29	99	82	219	39	95	85
	%	(86)	(69)	(92)	(85)	(95)	(100)	(92)	(97)
Partially immunized	N	20	8	4	8	3	-	2	1
	%	(8)	(19)	(4)	(8)	(1)	-	(2)	(1)
Not immunized	N	4	3	1	-	5	-	3	2
	%	(2)	(7)	(1)	-	(2)	-	(3)	(2)
Immunization status unknown	N	11	2	3	6	3	-	3	-
	%	(4)	(5)	(3)	(6)	(1)	-	(3)	-
Base: total children 4 years or younger	N	245	42	107	96	230	39	103	88

Table VII-2b. DPT: immunization of all children 4 years or younger - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Fully immunized appropriate for age	N	99	13	34	52	96	19	33	44
	%	(77)	(54)	(77)	(85)	(88)	(90)	(85)	(90)
Partially immunized	N	12	2	5	5	8	2	4	2
	%	(9)	(8)	(11)	(8)	(7)	(10)	(10)	(4)
Not immunized	N	17	9	5	3	4	-	2	2
	%	(13)	(38)	(11)	(5)	(4)	-	(5)	(4)
Immunization status unknown	N	1	-	-	1	1	-	-	1
	%	(1)	-	-	(2)	(1)	-	-	(2)
Base: total children 4 years or younger	N	129	24	44	61	109	21	39	49

Table VII-3a. Polio: immunization of all children 4 years or younger - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW*	SHORT	LONG	TOTAL	NEW*	SHORT	LONG
Fully immunized appropriate for age	N	215	31	99	85	209	38	91	80
	%	(88)	(74)	(92)	(89)	(91)	(97)	(88)	(91)
Partially immunized	N	19	5	6	8	1	-	1	-
	%	(8)	(12)	(6)	(8)	(*)	-	(1)	-
Not immunized	N	6	4	2	-	16	-	8	8
	%	(2)	(9)	(2)	-	(7)	-	(8)	(9)
Immunization status unknown	N	5	2	-	3	4	1	3	-
	%	(2)	(5)	-	(3)	(2)	(3)	(3)	-
Base: total children 4 years or younger	N	245	42	107	96	230	39	103	88

(*) less than 1%
* chi-square significant at .01 level

Table VII-3b. Polio: immunization of all children 4 years or younger - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW*	SHORT	LONG	TOTAL	NEW*	SHORT	LONG
Fully immunized appropriate for age	N %	101 (78)	13 (54)	34 (77)	54 (89)	90 (83)	18 (86)	30 (77)	42 (86)
Partially immunized	N %	11 (9)	2 (8)	5 (11)	4 (6)	10 (9)	3 (14)	4 (10)	3 (6)
Not immunized	N %	16 (12)	9 (38)	5 (11)	2 (3)	8 (7)	- -	5 (13)	3 (6)
Immunization status unknown	N %	1 (1)	- -	- -	1 (2)	1 (1)	- -	- -	1 (2)
Base: total children 4 years or younger	N	129	24	44	61	109	21	39	49

*Chi-square significant at .05 level.

Table VII-4a. Measles: immunization of all children 4 years or younger - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Fully immunized appropriate for age	N %	208 (85)	29 (69)	94 (88)	85 (89)	198 (86)	33 (85)	88 (85)	77 (88)
Partially immunized	N %	12 (5)	1 (2)	4 (4)	7 (7)	4 (2)	1 (2)	2 (2)	1 (1)
Not immunized	N %	18 (7)	8 (19)	8 (7)	2 (2)	21 (9)	2 (5)	10 (10)	9 (10)
Immunization status unknown	N %	7 (3)	4 (10)	1 (1)	2 (2)	7 (3)	3 (8)	3 (3)	1 (1)
Base: total children 4 years or younger	N	245	42	107	96	230	39	103	88

Table VII-4b. Measles: immunization of all children 4 years or younger - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL*	NEW⁑	SHORT	LONG	TOTAL*	NEW⁑	SHORT	LONG
Fully immunized appropriate for age	N %	86 (67)	6 (25)	31 (70)	49 (80)	86 (79)	15 (71)	32 (82)	39 (80)
Partially immunized	N %	6 (5)	- -	4 (9)	2 (3)	3 (3)	- -	2 (5)	1 (2)
Not immunized	N %	35 (27)	17 (71)	9 (20)	9 (15)	15 (14)	5 (24)	5 (13)	5 (10)
Immunization status unknown	N %	2 (1)	1 (4)	- -	1 (2)	5 (4)	1 (5)	- -	4 (8)
Base: total children 4 years or younger	N	129	24	44	61	109	21	39	49

* chi-square significant at .05 level

⁑ chi-square significant at .01 level

Table VII-5a. German Measles: immunization of all children 4 years or younger - urban.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Fully immunized appropriate for age	N %	200 (82)	29 (69)	88 (82)	83 (86)	189 (82)	32 (82)	86 (83)	71 (81)
Partially immunized	N %	10 (4)	1 (2)	3 (3)	6 (6)	2 (1)	1 (3)	- -	1 (1)
Not immunized	N %	20 (8)	7 (17)	10 (9)	3 (3)	27 (12)	4 (10)	11 (11)	12 (14)
Immunization status unknown	N %	15 (6)	5 (12)	6 (6)	4 (4)	12 (5)	2 (5)	6 (6)	4 (4)
Base: total children 4 years or younger	N	245	42	107	96	230	39	103	88

Table VII-5b. German Measles: immunization of all children 4 years or younger - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW*	SHORT	LONG	TOTAL	NEW*	SHORT	LONG
Fully immunized appropriate for age	N	80	6	28	46	80	13	28	39
	%	(62)	(25)	(64)	(75)	(73)	(62)	(72)	(80)
Partially immunized	N	4	-	2	2	3	-	2	1
	%	(3)	-	(4)	(3)	(3)	-	(5)	(2)
Not immunized	N	37	17	12	8	20	7	8	5
	%	(29)	(71)	(27)	(13)	(18)	(33)	(21)	(10)
Immunization status unknown	N	8	1	2	5	6	1	1	4
	%	(6)	(4)	(4)	(8)	(6)	(5)	(2)	(8)
Base: total children 4 years or younger	N	129	24	44	61	109	21	39	49

* chi-square significant at .05 level.

As can be seen from these Tables, responses were coded for three immunization statuses and status unknown. "Partially immunized" appears as a category because many respondents reported this as a status. However, it should be realized that, in the case of measles and German measles, one shot is all that is needed for a child to be fully immunized. Therefore, a response of "partially immunized" should really be translated to mean "not immunized appropriate to age."

In all cases, a greater proportion of urban than rural parents report that their children are immunized appropriate to age. While the vast majority of all children are in this category, particularly at T2, in most cases only the long-time rural members attain as high a percentage of immunized children as do urban subjects.

The greatest percentages for full immunization occur in relation to the DPT. Percentages for polio, measles, and German measles are successively lower. When T1 and T2 data for DPT are taken as a whole, it can be seen that the largest increase in the category of fully immunized occurred among children of new parents; there is a difference of 33 percentage points from the first interview period to the second. At T1, children of new parents were 21 percentage points below the next lowest group of fully immunized children. This pattern holds for other types of immunizations. Such increases among new participants can be attributed to the impact of PCC efforts in the area of health care.

Inspecting the data on DPTs, broken down by locale and longevity, the increases among new members become even more meaningful. Within the urban subsample, 69% of the children of new members had been fully immunized at T1, and at T2 this percentage reaches 100. In terms of a percentage point difference, new rural members showed a greater increase than their urban counterparts, however, 10% of these children are reported to be only "partially immunized," i.e., they may have one or two of the three necessary shots.

The pattern in terms of polio shots is similar to that for DPTs. However, here the percentage for partially or not immunized children is higher. While there has been an improvement in immunization record from T1 to T2, at T2 7% of the urban and 16% of the rural parents' children are still unimmunized. The percentage for rural short-time members' children (23%) is particularly high. For this type of immunization, both urban and rural new subjects reported significant increases in the number of children fully immunized. As a result of polio having been almost completely "wiped out" in the past few years, parents have become somewhat lax about the necessity of having children fully immunized against this disease. At a time when there is increasing concern over the possibility of a polio epidemic, it would seem that an expanded effort to obtain immunizations is needed.

Percentages for full immunization against measles are lower than those for either DPT or polio. However, signigicant improvement was achieved among new rural parents. At T1, only one-quarter of these parents reported that their children were fully immunized, whereas at T2, this was true of 71% of this group. Still, as with polio, the data show a fairly high proportion of respondents whose children are not immunized; 11% of the urban children and 17% of the rural. Although 17% of the rural children are unimmunized, this represents a statistically significant decrease over the T1 status.

The proportion of parents who report their children to be fully immunized against German measles is the lowest among all the shots previously discussed. At T2, only 79% of the total number of children were immunized appropriate to age; the most marked and statistically significant improvement occurred among children of new rural parents. In T1, almost three-quarters of the new rural children were not immunized, whereas in T2 this figure dropped to one-third. While the importance of this increase should not be minimized, it should be noted that there still remain 13% of the urban and 21% of the rural children who are unimmunized.

2.3 Medical check-ups

It has often been said that the population served by PCC goes to see a doctor only when there is sickness; they do not go to a doctor for preventive health check-ups, only for cure. PCCs have stressed the need for regular check-ups for all family members. Thus, an increase from T1 to T2 in the number of new families seeing a doctor for routine check-ups should be visible.

2.3.1 Check-ups during the first year of life.

Table VII-6a. Number of routine check-ups during first year of life - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
No visits	N	13	4	6	3	12	4	7	1
	%	(10)	(15)	(10)	(6)	(9)	(15)	(12)	(2)
1 visit	N	6	2	1	3	8	2	3	3
	%	(4)	(8)	(2)	(6)	(6)	(8)	(5)	(6)
2-3 visits	N	24	4	13	7	22	1	8	13
	%	(18)	(15)	(22)	(14)	(16)	(4)	(14)	(25)
4-5 visits	N	33	6	12	15	30	7	15	8
	%	(24)	(23)	(21)	(29)	(22)	(27)	(26)	(16)
6-8 visits	N	30	6	16	8	28	7	10	11
	%	(22)	(23)	(28)	(16)	(21)	(27)	(17)	(22)
9 or more visits	N	29	4	10	15	35	5	15	15
	%	(21)	(15)	(17)	(29)	(26)	(19)	(26)	(29)
Base	N	135	26	58	51	135	26	58	51

Table VII-6b. Number of routine check-ups during first year of life - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
No visits	N	7	1	4	2	5	-	2	3
	%	(9)	(7)	(14)	(6)	(7)	-	(7)	(9)
1 visit	N	7	2	2	3	8	2	4	2
	%	(9)	(14)	(7)	(9)	(11)	(14)	(14)	(6)
2-3 visits	N	28	4	9	15	22	3	7	12
	%	(37)	(29)	(32)	(45)	(29)	(21)	(25)	(36)
4-5 visits	N	18	3	8	7	25	7	11	7
	%	(24)	(21)	(29)	(21)	(33)	(50)	(39)	(21)
6-8 visits	N	10	2	4	4	11	2	3	6
	%	(13)	(14)	(14)	(12)	(15)	(14)	(11)	(18)
9 or more visits	N	5	2	1	2	4	-	1	3
	%	(7)	(14)	(4)	(6)	(5)	-	(4)	(9)
Base	N	75	14	28	33	75	14	28	33

At T1, forty-three percent of the urban and one-fifth of the rural respondents took their youngest child for six or more routine check-ups during the first year of life. Among the urban families, the trend in T1 was in the predicted direction; that is, fewer of the new (38%) than of the ongoing (45%) families took their babies for six or more medical visits. Whereas 15% of the new families reported no visits, only 8% of ongoing members made similar report.

Among rural families at T1, the trend is reversed. More new families (28%) than ongoing families (18%) report six or more visits. Similarly, fewer new families report no visits than is the case among ongoing members.

At T2, the patterns shift somewhat. In the urban subsample, there is an increase in the proportion of new families reporting six or more medical visits, while in the rural subsample a decrease in this category occurred among new members. At this time, new rural parents still maintained the lowest percentage of no visits.

Among the urban respondents, the modal number of visits for routine check-ups during the first year of life is over six: in the rural subsample it is between 2 and 5 visits, with the majority of respondents reporting 4-5 visits. In both subsamples, these numbers correspond to the recommended number of well-baby check-ups for a child under one year of age. There remains however, even at T2, a rather high proportion of parents who either do not obtain medical care for their children or report only one visit during the year: 15% of the urban families and 18% of the rural.

2.3.2 Check-ups for the child between 1 and 4

Table VII-7a. Number of routine yearly check-ups for children ages 1-4 - urban.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
No visits	N	37	10	15	12	39	10	14	15
	%	(27)	(38)	(26)	(23)	(29)	(38)	(24)	(29)
1 visit	N	18	2	7	9	37	5	13	19
	%	(13)	(8)	(12)	(18)	(27)	(19)	(22)	(37)
2-3 visits	N	44	7	19	18	45	7	25	13
	%	(33)	(27)	(33)	(35)	(33)	(27)	(43)	(25)
4-5 visits	N	15	1	8	6	9	3	5	1
	%	(11)	(4)	(14)	(12)	(7)	(12)	(9)	(2)
6-8 visits	N	14	4	7	3	1	-	-	1
	%	(10)	(15)	(12)	(6)	(*)	-	-	(2)
9 or more visits	N	7	2	2	3	4	1	1	2
	%	(5)	(8)	(3)	(6)	(3)	(4)	(2)	(4)
Base	N	135	26	58	51	135	26	58	51

(*) less than 1%

Table VII-7b. Number of routine yearly check-ups for children ages 1-4 - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
No visits	N	33	8	16	9	21	3	8	10
	%	(44)	(57)	(57)	(27)	(28)	(21)	(28)	(30)
1 visit	N	25	1	6	18	32	7	13	12
	%	(33)	(7)	(21)	(55)	(43)	(50)	(46)	(36)
2-3 visits	N	13	3	5	5	17	4	5	8
	%	(17)	(21)	(18)	(15)	(23)	(29)	(18)	(24)
4-5 visits	N	1	1	-	-	3	-	1	2
	%	(1)	(7)	-	-	(4)	-	(4)	(6)
6-8 visits	N	-	-	-	-	2	-	1	1
	%	-	-	-	-	(3)	-	(4)	(3)
9 or more visits	N	3	1	1	1	-	-	-	-
	%	(4)	(7)	(4)	(3)	-	-	-	-
Base	N	75	14	28	33	75	14	28	33

The data show that in T1 more rural parents (44%) did not take their children for check-ups than urban parents (27%). While the percentage of rural families in this category decreased 16 percentage points in T2, it seems clear from the previous table on number of check-ups during the first year of life, that parents in both samples are much more likely to take the baby to the doctor at that time than after the first year.

At T1, new parents, both urban (38%) and rural (57%) were less likely to take their babies over one year of age for check-ups than were long-time members (urban: 23%; rural: 27%). At T2, there are no changes reported by urban new parents , but there is some change reported by rural new parents. It should be noted, however, that a substantial number of all parents (25%) report that their children, ages 1-4, have not had a well-baby examination.

For those parents who do take their children for check-ups, the majority report between one and three visits per year. In the rural subsample the largest proportion of families (43%) were in the one annual visit category while in the urban subsample the greatest number of respondents (33%) report three to four check-ups.

2.3.3 Annual examinations for other family members

Table VII-8a. Annual examinations for other family members - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Annual examiniations	N %	108 (80)	21 (81)	47 (81)	40 (78)	110 (81)	22 (85)	49 (84)	39 (76)
No annual examinations	N %	27 (20)	5 (19)	11 (19)	11 (22)	25 (19)	4 (15)	9 (16)	12 (24)
Base	N	135	26	58	51	135	26	58	51

Table VII-8b. Annual examinations for other family members - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Annual examinations	N %	46 (61)	9 (64)	17 (61)	20 (61)	49 (65)	9 (64)	19 (68)	21 (64)
No annual examinations	N %	29 (39)	5 (36)	11 (39)	13 (39)	26 (35)	5 (36)	9 (32)	12 (36)
Base	N	75	14	28	33	75	14	28	33

As with all previous medical data, urban respondents showed higher percentages of positive responses. At T2, whereas 81% of urban families have had routine check-ups for other family members, only 65% of rural families have had such examinations.

Within each subsample, the differences across longevity are minimal. Differences from T1 to T2 are negligible as well. This being the case, it apparently seems that PCC has had no influence on whether or not other family members go for a routine physical examination. Regardless of PCC efforts, the majority of members' families report receipt of such care.

2.4 Dental check-ups for family members

2.4.1 Dental check-ups for respondents

Table VII-9a. Dental check-ups for respondents - urban.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW*	SHORT*	LONG*	TOTAL	NEW*	SHORT*	LONG*
Respondents reporting dental check-ups	N %	75 (56)	9 (35)	30 (52)	36 (71)	105 (78)	18 (69)	42 (72)	45 (88)
No dental check-ups	N %	60 (44)	17 (65)	28 (48)	15 (29)	30 (22)	8 (31)	16 (28)	6 (12)
Base	N	135	26	58	51	135	26	58	51

*Chi-square significant at .05 level.

Table VII-9b. Dental check-ups for respondents - rural.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Respondents reporting dental check-ups	N %	55 (73)	11 (79)	19 (68)	25 (76)	59 (79)	13 (93)	20 (71)	26 (79)
No dental check-ups	N %	20 (27)	3 (21)	9 (32)	8 (24)	16 (21)	1 (7)	8 (29)	7 (21)
Base: children of dental age	N	75	14	28	33	75	14	28	33

Within the urban subsample, each longevity subgroup showed a significant increase over time in the proportion of parents having received a dental check-up. At T2, the differences between groups are no longer as striking as was true at T1. While rural respondents also increased along this dimension, the gains over time are minimal.

2.4.2 Dental check-ups for children

Table VII-10a. Dental check-ups for children - urban.

RESPONSES		TIME 1				TIME 2			
		TOTAL	NEW*	SHORT	LONG	TOTAL	NEW*	SHORT	LONG
Received dental check-up	N %	176 (54)	5 (11)	43 (37)	128 (77)	210 (65)	23 (52)	59 (51)	128 (77)
Did not receive dental check-up	N %	149 (46)	39 (89)	72 (63)	38 (23)	125 (35)	21 (48)	66 (49)	38 (23)
Base: children	N	325	44	115	166	325	44	115	166

* chi-square significant at .001 level.

Table VII-10b. Dental check-ups for children - rural.

		TIME 1				TIME 2			
RESPONSES		TOTAL	NEW	SHORT	LONG	TOTAL	NEW	SHORT	LONG
Received dental check-up	N %	152 (70)	15 (48)	50 (65)	87 (80)	163 (75)	18 (58)	50 (65)	95 (87)
Did not receive dental check-up	N %	65 (30)	16 (52)	27 (35)	22 (20)	54 (25)	13 (42)	27 (35)	14 (13)
Base: children of dental age	N	217	31	77	109	217	31	77	109

A highly significant difference over time occurred in relation to the children of new urban parents. Whereas in T1 only 11% of the these children had been examined by a dentist, in T2 one-half (52%) of the children had received an examination. This finding is consistent with the data presented on dental check-ups among respondents. It is apparent that new urban families are receiving dental care that heretofore was either not available or not utilized by them prior to PCC participation.

With the exception of short-time rural and long-time urban members whose percentages were unchanged over time, data for all other subgroups show that a greater proportion of children are receiving dental check-ups in T2 than was the case in T1. None of these differences, however, is significant.

3.0 Nutrition

It had been predicted that as a result of PCC efforts and parent participation in programs on nutrition, ongoing members would be more aware of the need for well-balanced diets and would actually be more likely to serve nutritious meals than would new members. Thus, at T1, a portion of the questionnaire was devoted to measuring behavior in the area of nutrition by means of a 24 hour recall.

All of the nutrition data were coded in terms of the number of portions of various foods: e.g., red meats, green vegetables, proteins, etc. The data did not show a single difference between what new parents ate and served their children and what ongoing members ate and served their children. All groups tended to report the same staples and the same diets over a 24 hour period, whether for children or adults. Since there were no significant findings or trends in the data, this measure was dropped from the T2 interview.

4.0 Summary

- The majority of women saw an obstetrician six or more times during their last pregnancy. This was true of new mothers as well as those who had had a baby since joining PCC.
- Pre-natal care appears to be a service sought out by expectant mothers regardless of length of membership or level of involvement in PCC. Sixty percent of the sample report receiving pre-natal care during their first trimester of pregnancy; over 90% report receiving care no later than during the second trimester.
- At T1, a greater proportion of ongoing children, both urban and rural, had been immunized than was the case with new children. However, at T2 the number of new children who were fully immunized increased significantly, thus obliterating T1 differences.
- The majority of parents, regardless of length of membership or involvement level, took their children to the doctor four or more times during the child's first year of life.
- Urban parents took children to the doctor with greater frequency than did rural parents.
- The majority of parents had taken their 1 - 4 year old children to the doctor for a check-up during the past year. However, ongoing parents were more likely to have their children examined than were new parents.

- Urban parents tend to take their young children for check-ups more often than rural parents.
- While the majority of all adults have had an annual medical examination, urban adults are more likely than rural adults to receive such care. This is true regardless of length of membership or involvement.
- At T2 the majority of respondents report having had an annual dental check-up. The number of new, short and long-time urban members reporting receipt of such an examination increased significantly from T1 to T2.
- At T2 the majority of parents report that their children have had a dental check-up. The number of new urban children receiving such care increased significantly from T1 to T2.

CHAPTER VIII

THE IMPACT OF PCC: SOME FINAL THOUGHTS

When all of the data are compiled and all of the individual responses have been translated into numbers, coded and tabled, it seems that the impact of PCC has not been as great as was originally anticipated. Evaluation of changes over time yielded few significant results; respondents in one longevity subgroup often were similar to those in another, along the various study dimensions. The predictions that long-term and highly involved participants would most closely resemble "model parents" are not wholly borne out by the data. However, these findings are not peculiar to this particular evaluation: most studies of this nature serve more to highlight trends than to uncover major changes.

On the other hand, there is something operating within the framework of this evaluation that is too easily forgotten when only the hard data are inspected. Conversations with some mothers suggest that changes are indeed taking place. Staff members speak of important differences that have occurred as a result of PCC participation, and talks with individual mothers lend credence to such claims. There can be no question but that, among some, changes are taking place. Thus, while the PCC is having an impact upon some of its members, the manner in which these changes occur makes measurement difficult.

Each parent comes to the PCC with a unique set of experiences and needs. While the PCC population may be easily classified in terms of financial standing, employment status, health needs, etc.; and while national study demands that generalizations be made as to how problems are handled and how needs are perceived or met, such generalizations reflect group trends rather than individual variations. One parent needs to strengthen her social skills; another mother is unaware of available resources; while a third is concerned with coping with her child's behavior. The PCC can meet all of these needs. However, while it may give all three parents the same training, it will not have the same impact on each. Each mother will take from the PCC that which is most relevant to her perception of need. Thus, when the entire sample is measured, increased awareness in relation to a particular resource may be small and not statistically significant; however, a few individuals may have gained in this area. People change in various ways, and it is possible that the range and variety of changes is so great as to be obscured in the process of group comparison.

The data presented in this report were collected during structured interviews, a factor that bears consideration. While a working rapport between interviewer and parent was established in most cases, the situation remained somewhat stilted and artificial. In many instances, responses were tempered by perception of social desirability; this was particularly true of certain of the Likert items. For instance, one item reads: "I tend to feel shy with people." The subject is asked to respond along a time scale ranging from "seldom or never" to "most of the time or always." As one mother wrung her hands and whispered her answers, head down, she replied, "oh, never." Later during the open-ended portion of the questionnaire, this same mother said that she had always been shy and that coming to PCC was helping her learn how to meet people. The Likert item which related to shyness did not show major change nor impact; yet this woman, and many like her, are overcoming a personality characteristic which makes them uncomfortable through PCC participation. These types of gains and feelings emerge through informal conversation more frequently and more easily than they do through the structured portion of the interview. However, such conversations are often not reflected in data Tables: the chance therefore exists that real individual growth and change will be overlooked and overshadowed by objective measures taken from a large sample.

In order to avoid losing this valuable aspect of program impact, CCR staff members made special efforts to obtain case history-type interviews.

The following serve to illustrate the type of impact some of the new mothers report after only a short period of membership.

Mrs. Q. and her two children have been participants in a rural PCC for a little over two months. The family is visited by an outreach worker once a week. Mrs. Q. attends weekly parents' meetings, works with her children one to two hours each day on PCC-related activities and completes the activity form left by the worker. Mr. Q. was recently laid off from his job as a cement truck driver; he also participates in the program. With PCC assistance he has been enrolled in night school classes leading to a G.E.D. The children have received medical check-ups and immunizations as part of their induction into the program. In addition, the PCC nurse has taken care of an illness in the family.

In describing what PCC has meant to her, Mrs. Q. said: "It's helped me to raise my youngest children. I didn't know how to do it for my oldest daughter. She learned from Head Start. I've learned how to sit and play with them -- to teach them things. I have more patience with them and understand their moods. I realize now that they have needs and wants like any other person. I'm always kissing and hugging my kids -- something my parents never did. And I've learned to praise them. Our family is now closer together."

Mrs. L. is also a rural PCC participant. Since the death of her husband, Mrs. L. has maintained herself and her four children on social security, veterans' benefits and recently, food stamps. The family is involved in the PCC outreach program and Mrs. L. says that she spends approximately 30 minutes each day reinforcing the skills taught by the worker. The PCC, according to Mrs. L., has been of benefit to both herself and her children:

"Since I've joined PCC, I figured you got to make time to enjoy kids while they are little. I didn't like to take my kids anywhere. Since I've joined PCC and see other mothers do it I figure if they can, so can I. I accept my kids better, and I'm able to get along with other people easier... I've learned to participate in activities and I never knew picnics was that much fun till I went to PCC."

Mrs. G., is a young mother presently taking nursing courses at a local college. At the time of the interview, neither Mrs. G. nor her husband were working and so they received food stamps, medicaid and ADC for the baby.

Two months ago, when Mrs. G. enrolled her 7 month old son in this urban PCC, she was visited by both the PCC nurse and social worker who discussed with her which of her family's needs could be met by PCC. The social worker has since visited Mrs. G. four times and is responsible for encouraging her to return to school to become a nurse. The nurse has been coming once a week to speak to Mr. and Mrs. G. She has arranged for diabetes tests for the baby, as the disease runs in the family, and is trying to get medicaid coverage for the whole family.

Mrs. G. has attended six meetings for parents since joining the PCC. She finds these meetings helpful: "They give you a wide range of things to think about: potty training, emotions, nutrition. All the mothers get together and give ideas and you get a wide range of how to do things if one thing doesn't work. It's been quite interesting."

Mrs. G. also feels that the PCC has made a change in her personality: "I now like being around other people. Before coming to PCC I would only go somewhere like this with two or three other people. I started coming with a girlfriend. For some reason I liked it and I stayed. We all blended in."

As for her child, Mrs. G. hopes that: "he'll be able to learn a lot so that he can find his own way and be his own person. At the Center they teach things like holding a spoon, walking up stairs properly, sitting. They'll teach him mentally and physically and it'll mean better stability."

Formerly, Mrs. H. was receiving public assistance and was unemployed. She had recently become divorced and was responsible for raising her three children ages, 2,4 and 8.

The public assistance office informed Mrs. H. of a job opening at the nearby rural PCC. Mrs. H. was hired as a Center educator and is receiving on the job training. She is a paraprofessional, now taking her first two college courses with hopes of attaining a degree in child development.

As a staff member, Mrs. H. works with both mothers and children. She feels that, as a result of her experience with other children, she has learned to pay more attention to her own children: "I don't want to repeat a mistake my parents made raising us. That's not spending enough time with the children, not even reading an occasional book to us."

Mrs. H. says she feels her own children have gained substantially from the PCC program. "Their nutrition is better and they have learned to share, wait and socialize with others."

Mrs. H. also remarked that her feelings have changed "quite a bit" since joining the PCC:

" I don't lose my temper as much. I used to spank my children more than I do now. Now I try to talk to them and reason with them. I was brought up where spanking was the way to handle everything, but I don't agree with that. I've learned a lot about child development and ways to deal with crisis, and I can tell when they aren't getting all the attention they need."

Mrs. R. lives in an urban housing project with her husband, 4 year old daughter and 7 month old blind son. Her husband is in the Navy, stationed far from home, and so Mrs. R. bears the major portion of child-rearing responsibility alone.

For Mrs. R. an important part of PCC participation has been the monthly group discussions chaired by a visiting psychiatrist. "The help I get from other parents and the psychiatrist helps me to adjust to my son's blindness. PCC helped me to cope with him and I learned not to pamper him as much as I'd been doing. My daughter was beginning to react to the pampering by resenting her brother."

"Since she's (the daughter) been coming to PCC, she has become less hard-headed. She has more patience with toys and takes care of her stuff more. She is more polite with other children and has learned to get along better."

Mrs. R. says she is "very happy with PCC's work. I just want us to keep learning more. I've learned more about how to teach my kids before they go to school and how to get along with them and other people."

Mrs. D. and her two youngest children have been enrolled in a rural PCC for about two months. They come to the PCC twice a week and work together in the nursery. In addition, Mrs. D. is an active participant in regular parents' meetings. In the short time during which this family has been involved, Mrs. D. feels that she and her children have reaped considerable benefit from participation.

"It's good to get out, otherwise, I'm just at home with the kids. We both needed to meet other people. I'm learning how to do things at PCC. I've learned there's a lot of things you can learn with your children. Housework isn't as important as spending time with children. I've learned how to go about helping them develop with different kinds of toys. I have more patience too because I understand more."

In each of these cases, the PCC experience has provided the context and catalyst for change which might not appear significant when cast in strictly empirical terms. Mrs. G. described herself as a shy individual and said that she joined PCC to gain "social support" for herself and her children. After two months of participation, Mrs. G. is confident that "if I needed someone to talk to I could call upon a fellow PCC mother." It is difficult to measure the effects that this new "social support" will have on Mrs. G's attitudes toward herself and her family.

On a more tangible level, the PCC has done much to provide for the health needs of Mrs. P. and her family. "They give health insurance and dental care that my family never had before." During the course of the conversation, Mrs. P. and her children proudly showed the interviewer their recently cleaned teeth.

The PCC made an appointment for Mrs. B's son at a foot clinic for treatment of flat feet. The children were enrolled in a medical plan and received their long overdue immunizations. In addition, the family has received dental examinations."It's really a big help. Everywhere you called, dentists were filled up."

My youngest child has a heart murmur," said Mrs. F. "It was so hard to take care of him and now PCC helps. I wish I'd joined PCC sooner."

Said one mother in summing up her brief experience with PCC, "I wouldn't have known the first thing about kids without coming here."

The extent to which such responses reflect internalized knowledge can be questioned. Child development classes and workshops may foster an impression of knowledge which is not always fully internalized. For example, the very small number of mothers who mention the child's behavior in the context of age or of situational variables suggests that, for many mothers, there is relatively little internalization and/or generalization.

Such caveats notwithstanding, and the lack of general significant differences to the contrary, the trends expressed in the data, accompanied by both the open-end responses of the mothers and the general impressions of CCR professional staff suggest that, for some mothers at least, the PCCs have had meaningful impact. Given the diversity of program emphases and the diversity of participants' individual needs, it is not surprising that the nomethetic approach to evaluation yields few statistically significant indices of change. While such generalized objective measures are essential as program descriptors, they can and do obscure the nuances of individual change. The individual expressions of experience, and the self-reports of change, when viewed in the context of objective program descriptors, yield a picture of personal rather than group changes.